amend #5 Per FH G878 4/01/08 JH Department of Health and Mental Hygiene 1- State of Maryland / Department of Health 1- State Amend #31 per FCHD 01-07-2008 Conficate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Zabeth Kishe 2008 anvary /Medical 4a. Facility Name (If not institution, give street and 4b. City Town, or Location of Death 4c. County of Death Examiner University of 5.220 Security Number nedica 12a/timove bryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗙 F Days Hours Min. -70-6990 Director April 22, 1972 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Frederick Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6806 Wythe Court Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" th and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lab Tech 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Allan Bernard Janice Menghi 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 Is any Injury or other trac 6806 Wythe Court Frederick, Maryland 21703
ace of Disposition (Name of Date 20c. Location - City or Town, State Steven Kisner (husband) Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specify) Entombment Mt. Olivet Cemetery Jan. 8, 2008 Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 27a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -> Y how /Medical to (or as a consequence of Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9☐Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No 1☐ Yes Physician: neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 Tes 1 Inpatient 2
Date of Injury
(Month, Day Year) 2 ER/Outpatient 3□ DOA Manner of Death 28b. Time of 28c. Certification: 28d. Describe how injury occurred Injury at Work? or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and offer certification 29c. License number 29d. Date signed (Month. Dav. Year) 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De State of Maryland / De Registrar		ment of He		nd Me		ene (08	01002
	Dharaini	ų.	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month Jan		Year	3. Time of Death
	Physicia /Medic		Edward Craig Kercheval	132			D 1 h	Jan	6 2 4c. County	008	9:50 P M
	Examin	er	4a. Facility Name (If not institution, give street and number) 20423 Holt Circle	46.	b. City, Town, or Location of Death Hagerstown					shing	ton
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		Under 1 Year	If Under 24	Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign
	Director		201–16–0128 ¹ ⊠ ^{M 2□ F} 79 Yr	s. Mo	onths Days	Hours	Min.	Apr 30,	1928	Cour	PA
	and W		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	or Locatio	on						10d. Inside City Limits
	Maryli f sho	tor	MD Washington	Hage	rstown						1 □ Yes 2 🌠 No
	h the	Director	10e. Street and Number	10	Of. Zip Code			10	g. Citizen of		
	ath wil	raiD	20423 Holt Circle			2174			14 Da	USA	can Indian,
	ter de: Itams Iter :	Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married 1 □ Never Married 2 ☑ Married	13. Was	Decedent of His s, specify Cuban	panic Origi , Mexican, I	n? (Spec Puerto F	lican, etc.)		ck, White,	
92	should be filed within 72 hours after death with the Maryland nd Mental Hyglene i markad othar than "natural", or itams 23a or 28a-f show umatic evant, if w. M. ofcal Ex. nitter i ust be notified	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 🗆 ነ	Yes 2∏ No	Specify:			Speci	fy: 	White
21215-003	72 hc	etec	15. Decedent's Education 16a. D (Specify only highest grade completed)	Give kind	s Usual Occupat of work done du NOT use retired)	tion u <i>ring</i> most o	of workin	g 1	6b. Kind of E	Business/In	ndustry
72	withir iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		superi	_			Schoo	1syst	em
힏	e filed al Hyg othal	BeC	17. Father's Name (First, Middle, Last)					(First, Middle, M	aiden Suma	me)	
<u>X</u>	should be ind Mental s markad o umatic eva	To	James Franklin Kercheval				e Cr		A11 =	21.1.7	0.41
Maryland	d 2 sh th and 7 Is m traum		1 1 1 1					Route Number, erstown			(Code)
	ages 1 and 2 should but of Health and Ment It If Itam 27 Is markac For other traumatice		20a. Method of Disposition 20b. Place of Disposition	Disposition	-				Oc. Location		own, State
altimore,	Pages nent of int: If its iry or o		1 X Burial 2 □ Cremation 3 X Removal from State '4 □ Donation 5 □ Other (Specify) Green H	i11	Cemeter	y 01		2008 Wa			
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligensee					e-Bower Jaynesbo			Home, Inc.
			23a. Part I. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter th	ne mode of dying	, such as ca	ardiac o	respiratory arre	st,		Approximate Interval Between
-	Physician	į į	Immediate Cause (Final disease or condition	10	e/2						Onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):						1	
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury):							
	ecuted and transit	Examiner	that initiated events	i).							
760,	The law requires that the death certificate be executed tae has been signed by the attending physician and tae has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	ai E	Due to (or as a consequence of)-							
89	tificate g phys as the	ledicai	0.								
Вох	leath certifica attending ph	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Live birth 2□ Fetal death		opic pregnancy					ate of deliv	very Day Year
P.O. E	that the death cer ed by the attendin detached for use	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 🗌 Oth	her (specify)						
	res that the signed by be detact		Part II. Other significant conditions contributing to death but not resulting in t	the under	rlying cause give	n in Part I.		23e. Did tob	acco use co	ntribute to	the cause of death?
rds	w requires been sign should be	ed by						1)⊠ Ye	s 2 🗆 No	3 □ Pro	bably 4 Unknown
ဓင္ဓဝ	e faw requ has been ge 2 should	Completed						24a. Was ar autops	/	prior to c	opsy findings available ompletion of cause of
Vital Records,	ysician: The is certificate hadirector, page							perform 1 Tes 2	™ No	death?	2 No
	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	nationt 3	3□ DOA Othe			(Check only one		ther (Snec	ifv)
10	Attanding Physician: # death. actor: After this certifics by the funeral director, p	n: To	27. Magner of Death 28a. Date of Injury 28b. Ti		28c. Injury Work			28d. Describe ho			,,
Sior	andin eath. or: Afi	atio	2 Accident investigation		M 1 1	/es 2□N					Courte Manhar
Division of	in the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	m, street,	factory, office			City or Town	, State)	nber or Au	ral Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and	death oc	curred at the tim	e, date and	l place, a	and due to the ca	iuse(s) and r	nanner as	stated.
	tha Ho nin 24 tha Fi	Aedical	one) and manner stated.	/or invest			1 000011		9d. Date sign		
	Vitil Con	M	29b. Signature and title of certifier		29c. License	_	. C .		/ / >	/_ ~	
	سـ ، و.	_	30. Name and address of person who completed cause of death (Item 23a) (T	Гуре, Prin	1000 THI LISA		312	BOTHA	M	7 7	2/142
فل	11-15+1		11110 MEDICAL CAMPUS.	D, y	ve .	مرايد	· /±	130 1-	Age	1000	ON MO
	Sta Regist		31. Date liled (Month, Day, Year) JAN 0 8 2008 32. Registrar's Signature	1					0		
	, legisti	5 4	JAN 0 0 2000	AAD.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) Sophia Constance Keeler 2. Date of Death **Physician** Jahouary 4 2008 23:11P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5 Social Security Number 019–16–0435 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. January 22 1923 84 Massachusetts Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at b. County Calvert Maryland Prince Frederick 1 ☐ Yes 2 ☐ No Director 10e Street and Number 401 Paula Terrace 10f 20678 10g Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No white Baltimore, Maryland 21215-0036 1 □ Yes 2☐No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) accounting bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Karakula Madeline Balinsky ပ 19a. Informant's Name/Relationship (Type. Print) Frank Ivanosich - son 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Funeral service 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Alexandria Virginia 4 Donation 5 DOther (Specify) Raisch Fineral Hore PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility any in 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (Dryest **Physiclan** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. Anemia burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 ☐ Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Fallurg 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 s autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes P 2 ER/Outpatient 3 DOA 1 Inpatient this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 ☐ Accident Injury 5 Pending n 24 hours after death.
he Funeral Director: A pletely filled in by the ft. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title 29d. Date signed (Month, Day, Year) 00061947 08

Jun 10

DHMH 17 Rev 1/2001

State S Registrar

31. Date filed (Month, Day, Year)

Year) 32. Registra

30. Name and address of person who completed cause of death (trem 23a) (Type, Print) MACO MACO Prince Frederick MD 20078

32. Registra Signature

& Sports

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00118 State of Maryland / Department of Health and Mental Hygiene Arthur William Lankford, III Certificate of Death 1. For State Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2051 hrs January 4, 2008 ARTHUR WILLIAM LANKFORD III Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Eden 26760 Siloam Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min Country) 05/10/1950 Director 57 218-48-8060 1 X M Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State Yes 2 No s 23a or 28a-f show e notified at ouce. 28a-f show Salisbury Wicomico Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other tranmatic event, the Medical Examiner must be notified at once. 10g. Citizen of What Country? Director 10f, Zip Code 10e. Street and Number USA 705 Burning Tree Circle 21801 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. Armed Forces Never Married 2 Yes Specify: White Yes 2 X No specify: If Yes. Give Year 4 X X Divorced Widowed ₫ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) pe during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet Entrepreneur Accountant 12 6 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur William Lankford, Doris Benson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Delmar, MD 21875 Kyle Lankford/ Son 403 East Walnut Street, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 1/7/08 Pocomoke, MD 21851 Pitts Creek Presb Other Specify. Donation 5 22. Name and Address of Facility 103 Linden Ave. 21. Signature of Funeral Service Licensee Pocomoke City, MD Holloway Funeral Home, P.A. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death /Medical a. Hanging Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit the Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical AMENDED for use as the burial -UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown by the a Phy 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. o Yes 2 No 3 Probably 4 ✔ Unknown þ ۵ Completed 24b. Were autopsy findings available 24a. Was an Records, been should prior to completion of cause of autopsy death? has performed Yes 2 V No No Yes 2 26.Place of Death (Check only one 25. Was case referred to medical of Vital Be Other₄ Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient 2 this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death Subject hanged self Certification: FOUND: Yes 2 ✔ No Natural Division Pending Director: hin 24 hours after death Jan 4, 2008 2040 hrs 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide or Town, State) 26760 Siloam Road, Eden, MD Could not be determined (Specify) Old chicken house Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier **OCME** January 5, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) histore M. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar	State of Mi	aryland / De <i>C</i>	ertificate of		id Meritar i	Reg. No	7111	8 0100
, 5 - 8	æ	1. Decedent's Name (First, Middle, La	ist)				2. Date o	f Death		3. Time of Death
Physicia /Medic		Hubert Gehr Mu	mma				Janua			08:50 P M
Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	or Location of I	Death		. County of Deat	
	8	NMS Healthcare o	of Hagersto	own	Hagerst	own		W V	Vashingt	on
Funeral		5. Social Security Number 6. S		e (In yrs. last birtho	Months Days		Hrs. 8. Date o	f Birth , Day, Year)	9. Birti	hplace (State or Foreign
Director		214-16-0020	1 X M 2 L F	84 Yrs			2/2/			yland
and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	Location					10d. Inside City Limits
Aaryli f sho	ō									1 Yes 2 No
death with the Maryland ms 23a or 28a-f show Fraust be ricelified	by Funeral Director	Maryland Washingt	on	Hagersto	10f. Zip Code			10g. Ci	tizen of What Co	untry?
with Ma or	ă		٦.		21740				J.S.A.	,
leath	era	11104 Lakeside C	12. Was Decedent	Ever in U.S.	3. Was Decedent of H	Hispanic Origin	n? (Specify Yes o	r No-	14. Race - Ame	nican Indian,
fter of trend	ᇤ	1 ☐ Never Married 2 📆 Married	Amed Forces? 1 X Yes 2 If Yes, Give		If Yes, specify Cub	an, Mexican, I	Puerto Rican, etc.	.)	Black, White	e, etc.
OU36 hours after turel; or Ite		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:			Specify:	hite
13-UU30 172 hours after death with the Marylan "neturel", or Items 23a or 28a-f show Glost Examiner man be notified at	Completed	15. Decedent's E (Specify only highest gro		16a. D	ecedent's Usual Occup ive kind of work done	pation	of wadking	16b. K	(ind of Business/	Industry
vithin 72 sne.	pie	Elementary/Secondary (0-12)	College (1-4or		e. DO NOT use retire	d)	or working			
filed wi Hygien other th	Sol	7		Pu	nch Out Pe				onstruct	ion
D d oth	Be	17. Father's Name (First, Middle, Last	1)				s Name (First, Mi			
aryiand should be in and Mental I s marked or umatic eve	္	Daniel Gehr Mum				Ther			nmerly_	
ore, Maryiand stand 2 should be fit if Health and Mental Hy item 27 is marked oth	8	19a. Informant's Name/Relationship ((Type, Print)	19b. M	ailing Address (Street	and Number	or Rural Route N	umber, City	or Town, State, 2	Zip Code)
		Margie A. Mumma /	/ Wife	111	04 Lakesid	e Ct.	Hagersto Date			
Ore Profit		20a. Method of Disposition 1	Removal from State	cemetery,	sposition (Name of crematory or other pla	ce)	Date	20c. L	ocation - City or	Town, State
IIM trmen tant: jury		*4 □Donation 5 □ Other (Special		Cedar L	awn Cemete		/9/2008	Hay	erstown	, Maryland
Baltimore, permit. Pages 1 an Oppartment of Heal Important: If Item 2 eny injury or other ance.		21. Signature of Funeral Service Lice	9800		22. Name and Addre		ICODE III		ineral C	•
ans a		he h.	han						town Mar	yland 21742
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	d the death. Do not ne.		_	ardiac or respirato	ory arrest,		Approximate Intervat Between Onset and Death
Physician	7	Immediate Cause (Final disease or condition	_aCo	ronor	1 Art.	XY Y	Disc	ase		Orisot and ocativ
/Medical Examiner		resulting in death)							[
Exam.			,	a consequence of)						
	į.	Sequentially list conditions,	,							
be disit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	a consequence of)	nsion	. () (
xecuted and Il-transit	xamlner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	aconsequence of)		0515				
be executed be executed incident and purial-transit	ai Examlner	that initiated events	b. Due to (or as		nsion	0515				
58 / 60, rcate be executed physician and s the burial-transit	Icai	that initiated events	b. Due to (or as	aconsequence of)	nsion	0515				
X 68 / 60, certificate be executed iding physician and use as the burial-transit	Icai	resulting in death) Last	b. Due to (or as	aconsequence of)	nsion	0515			23d Date of de	livery
BOX 68 / 60, eath certificate be executed attending physician and for use as the burial-transit	Icai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	aconsequence of) ortic a consequence of) of pregnancy 2 Fetal death	M S, on Sten 3□Ectopic pregnanc				23d. Date of del Month	livery Day Year
.O. BOX 68/60, the death certificate be executed y the attending physician and iched for use as the burfat-transit	Icai	IF FEMALE: 23b. Was decedent pregnant	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome	aconsequence of) ortic a consequence of) of pregnancy 2 Fetal death	ns, on Sten					,
P.O. BOX 63 hat the death certific d by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	aconsequence of) ortic a consequence of) of pregnancy 2 Fetal death t time of death	Sten Sten 3 Ectopic pregnanc 5 Other (specify)	y			Month	,
P.O. BOX 63 hat the death certific d by the attending p detached for use as	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death t	aconsequence of) a consequence of) of pregnancy The first death out not resulting in the	Sten Sten 3 Ectopic pregnanc 5 Other (specify)	y	23e.	Did tobacco	Month	Day Year the cause of death?
P.O. BOX 63 hat the death certific d by the attending p detached for use as	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	aconsequence of) a consequence of) of pregnancy The first death out not resulting in the	Sten Sten 3 Ectopic pregnanc 5 Other (specify)	y	23e.	Did tobacco 1 ☐ Yes 2	Month use contribute to	Day Year of the cause of death? robably 4 DUnknown
P.O. BOX 63 hat the death certific d by the attending p detached for use as	by Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death t	aconsequence of) a consequence of) of pregnancy The first death out not resulting in the	Sten Sten 3 Ectopic pregnanc 5 Other (specify)	y	23e. 	Did tobacco 1 □ Yes 2 Was an autopsy performed?	Month use contribute to No 3 Pr 24b. Were at prior to death?	Day Year of the cause of death? robably 4 Dunknown utopsy findings available completion of cause of
I HECOrds, P.O. BOX 6: The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death t	aconsequence of) a consequence of) of pregnancy The first death out not resulting in the	Sten Sten 3 Ectopic pregnanc 5 Other (specify)	y ven in Part I.	23e. 24a. 1 🗆 Y	Did tobacco 1 Yes 2 Was an autopsy performed? es 2 N	Month use contribute to No 3 Pr 24b. Were at prior to death?	Day Year of the cause of death? robably 4 Dunknown utopsy findings available completion of cause of
I HECOrds, P.O. BOX 6: The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	o Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of examiner?	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death the second of the second	aconsequence of) ortic a consequence of) of pregnancy Consequence of) of pregnancy Consequence of) of pregnancy Consequence of)	Sten 3 Ectopic pregnanc 5 Other (specify)	yen in Part I. 26. Place c	23e. 24a. 1 □ Y	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 Northy one)	Month use contribute to No 3 Pr 24b. Were at prior to death? 1 Yes	Day Year of the cause of death? robably 4 DUnknown utopsy findings available completion of cause of
I HECOrds, P.O. BOX 6: The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions examiner? 1 Yes 2 No 27. Manner of Death	b. Due to (or as c. Due to (or as d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown contributing to death the series of the serie	aconsequence of) ortic a consequence of) of pregnancy 2 Fetal death t time of death out not resulting in the	3 Ectopic pregnanc 5 Other (specify)	ven in Part I. 26. Place c	23e. 24a. 1 Y of Death (Chack c	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 Northy one)	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Spe	Day Year of the cause of death? robably 4 DUnknown utopsy findings available completion of cause of
n of Vital Records, P.O. Box 6: ng Physicien: The law requires that the death certific firer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death b Mospital: 1 Inpati	aconsequence of) ortic a consequence of) of pregnancy 2 Fetal death t time of death out not resulting in the	3 Ectopic pregnanc 5 Other (specify) e underlying cause growthing cause growth	ven in Part I. 26. Place c	23e. 24a. 1 □ Y of Death (Check cosing Home 5 □ 28d. Desc	Did tobacco 1 Yes 2 Was an autopsy performed? es 2 North one) Residence	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Spe	Day Year of the cause of death? robably 4 DUnknown utopsy findings available completion of cause of
n of Vital Records, P.O. Box 6: ng Physicien: The law requires that the death certific firer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death the series of	aconsequence of) a consequence of) a consequence of) of pregnancy 2 Fetal death time of death out not resulting in the	3 Ectopic pregnanc 5 Other (specify) e underlying cause growthing cause growth	yen in Part I. 26. Place of ther. 4/2/Nurs	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? es 2 No. Residence ribe how injuited in the control of the cont	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Spe	Day Year of the cause of death? robably 4 DUnknown utopsy findings available completion of cause of
n of Vital Records, P.O. Box 6: ng Physicien: The law requires that the death certific firer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death the series of	aconsequence of) of pregnancy 2 Fetal death t time of death out not resulting in the	Sten 3 Ectopic pregnanc 5 Other (specify) e underlying cause gri	yen in Part I. 26. Place of ther. 4/2/Nurs	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? Yes 2 Norly one) Residence ribe how inju	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Spe	Day Year of the cause of death? robably 4 DUnknown utopsy findings available completion of cause of
n of Vital Records, P.O. Box 6: ng Physicien: The law requires that the death certific firer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death to the series of Injury (Month, Date of Input) 28a. Date of Injury (Month, Date of Input) 28b. Place of Input) contributions to the best of the best of the series o	aconsequence of) a consequence of) of pregnancy 2 Fetal death t time of death out not resulting in the out not resulting in the put not resulting in the consequence of) a consequence of of our consequence of our c	3 Ectopic pregnanc 5 Other (specify) e underlying cause gri titient 3 DOA e of 28c. Injury M 1 c, street, factory, office	26. Place of ther: 42 Nurs ry at rk? Yes 2 \(\sum \) No.	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 No inly one) Residence ribe how injuited in the cause (see the cause (s	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred	Day Year Dithe cause of death? Tobably 4 Dunknown Litopsy findings available completion of cause of security) Litopsy findings available completion of cause of security.
n of Vital Records, P.O. Box 6: ng Physicien: The law requires that the death certific firer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death the series of the series of the series of the building, e	aconsequence of) a consequence of) b consequence of) a consequence of of consequence of of consequence of consequen	3 Ectopic pregnanc 5 Other (specify) e underlying cause grown with titlent 3 DOA of the off y Mo 1, street, factory, office eath occurred at the transvestigation, in my office eath occurred at the transvestigation.	26. Place of them at rick? Yes 2 Note that and opinion, death	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 No. 10 No.	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred and Number or Rete) s) and manner as did place, and due	Day Year Dithe cause of death? Tobably 4 Dunknown Litopsy findings available completion of cause of security) Litopsy findings available completion of cause of security.
P.O. BOX 63 hat the death certific d by the attending p detached for use as	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as d. Pregnant a go Unknown contributing to death to the following to death to the following to death to the following to the	aconsequence of) a consequence of) b consequence of) a consequence of of consequence of of consequence of consequen	3 Ectopic pregnanc 5 Other (specify) e underlying cause grown with titlent 3 DOA of the off y Mo 1, street, factory, office eath occurred at the transvestigation, in my office eath occurred at the transvestigation.	26. Place of them at rick? Yes 2 Note that and opinion, death	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 No. 10 No.	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred and Number or Rete) s) and manner as did place, and due	Day Year the cause of death? robably 4 Dunknown utopsy findings available completion of cause of 2 No rotify) ural Route Number, s stated. a to the cause(s)
n of Vital Records, P.O. Box 6: ng Physicien: The law requires that the death certific firer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as c. Due to (or as d. Due to (or as d. Due to (or as d. Pregnant a go Unknown contributing to death to the following to death to the following to death to the following to the	aconsequence of) a consequence of) b consequence of) a consequence of of consequence of of consequence of consequen	3 Ectopic pregnanc 5 Other (specify) e underlying cause grown with titlent 3 DOA of the off y Mo 1, street, factory, office eath occurred at the transvestigation, in my office eath occurred at the transvestigation.	26. Place of them at rick? Yes 2 Note that and opinion, death	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 No. 10 No.	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred and Number or Rete) s) and manner as did place, and due	Day Year the cause of death? robably 4 Dunknown utopsy findings available completion of cause of ca
UIVISION Of VITAI HECONDS, P.O. BOX 6: To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death the service of Injunction of the building, e completed cause of the service of the	aconsequence of) a consequence of) b consequence of) a consequence of of consequence of of consequence of consequen	3 Ectopic pregnanc 5 Other (specify) e underlying cause grown with titlent 3 DOA of the off y Mo 1, street, factory, office eath occurred at the transvestigation, in my office eath occurred at the transvestigation.	26. Place of them at rick? Yes 2 Note that and opinion, death	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 No. 10 No.	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred and Number or Rete) s) and manner as did place, and due	Day Year the cause of death? robably 4 Dunknown utopsy findings available completion of cause of 2 No rotify) ural Route Number, s stated. a to the cause(s)
n of Vital Records, P.O. Box 6: ng Physicien: The law requires that the death certific firer this certificate has been signed by the attending p ineral director, page 2 should be detached for use as	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death to 28a. Date of Injuic (Month, Da be 28e. Place of In building, e thysician: To the best and manner st completed cause of the complete cause of the cause of the complete cause of the cause of the complete cause of the ca	aconsequence of) a consequence of) b consequence of) a consequence of of consequence of of consequence of consequen	3 Ectopic pregnanc 5 Other (specify) e underlying cause grown with titlent 3 DOA of the off y Mo 1, street, factory, office eath occurred at the transvestigation, in my office eath occurred at the transvestigation.	26. Place of them at rick? Yes 2 Note that and opinion, death	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 No. 10 No.	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred and Number or Rete) s) and manner as did place, and due	Day Year the cause of death? robably 4 Dunknown utopsy findings available completion of cause of 2 No rotify) ural Route Number, s stated. a to the cause(s)
UIVISION Of VITAI HECONDS, P.O. BOX 6: To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as c. Due to (or as d. Due to (or as d. Pregnant a 9 Unknown contributing to death to 28a. Date of Injuic (Month, Da be 28e. Place of In building, e thysician: To the best and manner st completed cause of the complete cause of the cause of the complete cause of the cause of the complete cause of the ca	aconsequence of) a consequence of) b consequence of) a consequence of of consequence of of consequence of consequen	3 Ectopic pregnanc 5 Other (specify) e underlying cause grid underlying cause grid le of y M 1 Company	26. Place of them at rick? Yes 2 Note that and opinion, death	23e. 24a. 1	Did tobacco 1 Yes 2 Was an autopsy performed? (es 2 No. 10 No.	Month use contribute to 2 No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Speury occurred and Number or Rete) s) and manner as did place, and due	Day Year the cause of death? robably 4 Dunknown utopsy findings available completion of cause of 2 No rotify) ural Route Number, s stated. a to the cause(s)

			1- State of Registrar		artment of Health a rtificate of Death		rgiene Reg. No. 2008	ninns
	71.5		Decedent's Name (First, Middle, Last)			2. Date of De	eath	3. Time of Death
	Physici /Medic		Harry Webster Mullini:	X		Januar	y 4, 2008	18:45 P M
)	Examin		4a. Facility Name (If not institution, give street and numb	oer)	4b. City, Town, or Location	of Death	4c. County of Deat	
			11832 Linbar Dr. 5. Social Security Number 6. Sex 7	. Age (In yrs. last birthday)	Hagerstown If Under 1 Year If Under	24 Hrs. 8. Date of Bi	Washingto	
	Funeral Director		218-40-4155	67 Yrs.	Months Days Hours	Min. (Month, D.		hplace (State or Foreign untry)
Δ.	aliden militari un relegio		Usual Residence of Decedent			10/29/	1940 wasi	nington D.C.
	arylan show dat	_	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	he Ma 8a-f s	ecto	Maryland Washington	Hagerston				1 ☐ Yes 2 ☐ No
	a or 2	Di	10e. Street and Number		10f. Zip Code		10g. Citizen of What Co	untry?
	ns 23	Funeral Director	11832 Linbar Dr. 11. Marital Status 12. Was Deced	ent Ever in U.S. 13.	21742 Was Decedent of Hispanic Orl If Yes, specify Cuban, Mexica	igin? (Specify Yes or N	U.S.A. 0- 14. Race - Ame	rican Indian,
0	after o	Fur	1 Never Married 2 Married 1 Yes 2	2 □ No	_ \			e, etc.
3	ours a	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dat	es:	1 ☐ Yes 2 No Specify:		Specify: WI	nite
	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during mos DO NOT use retired)	st of working	16b. Kind of Business/	Industry
7	withir ene. than he Me	d mc	Elementary/Secondary (0-12) College (1-4	tor 5+)	erial Handler		Dublidabia.	_
א כ	filed Hygi other ent, t	a)	17. Father's Name (First, Middle, Last)	Male		er's Name (First, Middle	Publishing e, Maiden Surname)	<u></u>
0	uld be dental rked tlc ev	To B	Dyson F. Mullinix		T.	Ruth Farr	ier	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Health and Mental Hygiene. Tar is marked other than "natural", or items 23a or 28a-f show ther traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street and Numb	er or Rural Route Numb	ber, City or Town, State, 2	Zip Code)
	and and m 27		E. Eileen Mullinix/ wife	1183	2 Linbar Dr. I	Hagerstown	Maryland 21	742
5	Pages 1 and 2 ent of Health a ht: If item 27 is y or other trau		20a. Method of Disposition 1 → Burial 2 ☐ Cremation 3 ☐ Removal from St	tate 20b. Place of Dispo	nsition (Name of matory or other place)	Date	20c. Location - City or	Town, State
<u> </u>	it. Pa rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee	Kest Hav		L/9/2008	Hagerstown	
0	permit. Pages 'Department of H Important: If ite any Injury or ot once.		21. Signavita of Furieral Service Licensees		2. Name and Address of Facili 601 Pennsylvar			
	Sever to		23a. Part1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each			_		Approximate
1	Physician		Immediate Cause (Final	1972 F 1174				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or	r as a consequence of):	u Cardiov	es away !	JILOSE	1=(102,
	Examiner		Sequentially list conditions, b.					
	pe tis	Examiner	n arry, reading to hinnediate cause. Enter Underlying Cause (Disease or injury	rias a consequence offy:				
	xecut and Il-tran	xam	that initiated events	r as a consequence of):				
20	icate be executed physician and s the burial-transit	ia E						
000	ifficate g physas the	edical	d				12.50	
Š	h cerr endin	M/III	230. Was decedent pregnant	ome pf pregnancy th 2 ☐ Fetal death 3 ☐	□Ectopic pregnancy		23d. Date of de	ivery
	e deat he att	sicia	1 Yes 2 No 4 Pregna	nt at time of death 5	Other (specify)		Month	Day Year
	d by the	Physician/M	9 LI URRIOWII		ndoshina anun siyan in Dost l	220 Did	tobacco uso contribute to	ather province of decade?
ה מ	ires the signeral signeral	þ	Part II. Other significant conditions contributing to dea	in out not resulting in the u	ndenying cause given in Part i		tobacco use contribute to Yes 2 No 3 P	
colus,	v requ	Completed						
ב ב	he lav s has ge 2 :	ldm				24a. Was	ppsy prior to death?	itopsy findings available completion of cause of
2	in: Ti ifficate or, pa		25. Was case referred to medical		OS Plane	1 Yes e of Death (Check only	2 No 1 ☐ Yes	2 No
>	yslcir is cer direct	o Be	examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ In	patient 2 ☐ ER/Outpatier	Other		idence 6 □Other (Spe	cify)
5	ng Ph fter th neral	n: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month)	Injury 28b. Time o			how injury occurred	
2	tendii eath. or: A the fu	atic	2 Accident investigation		M 1 ☐ Yes 2 ☐			
2	or At ifter d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place o building	f injury - At home, farm, str g, etc. <i>(Specify)</i>	reet, factory, office	28f. Location City or To	(Street and Number or Ri own, State)	ural Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the b	est of my knowledge deat	h occurred at the time, date as	nd place, and due to the	cause(s) and manner a	stated
	e Hos 24 h e Fur letely	Medical	(Check only 2 Medical Examiner: On the bas	sis of examination and/or in	vestigation, in my opinion, de	ath occurred at the time	e, date and place, and due	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mont	h, Day, Year)
			Mayer g/sua	1	D28365		1-7-08	
1	1.0.1		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print)	3	at M	0 2 5
	-0+1	11	MAND AR. D. SHAF 31. Date filed (Month, Day, Year) 32. Reg	368 √ estrar's Signature	ull street	Heigh	entour 19	021140
	Sta Registr		IAN 0.8 2008	e la	look .	9		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3:20 AM Carmine Masucci 2008 Kobert lanuaru /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital Baltimore Cit If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Social Security Number **Funeral** Hours 121-12-8999 New York 83 June 25, 1924 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Garrett Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10700 Clemant Avenue 20896 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Taryes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Employee Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmine Rosario Masucci Maria Giovanna Summa ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra once. Rose A. Masucci/Wife 10700 Clermont Avenue, Garrett Park, MD 20896 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State January 7, Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Entombment 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic shock **Physician** hours /Medical Examiner 2 days Gram negative rod urosepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 2 weeks attending physician and for use as the burial-transit Due to (or as a consequence of): tract intection Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 9☐Unknown signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes been si should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA ို 27. Manner of Death 12 Natural 28b, Time of 28a. Date of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

executed Box 68760 certificate be Ö ۵. Records, or Vital Division

72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

0+1

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1. ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) and manner stated. 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier

Medical Doctor

January 2, 2008

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

Kendall Mospley, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287
31. Date filed (Month, Day, Year) 32 Aegistrar's Signature JAN 0 4 2008

29a. Certifier

Medical

Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, 2875 01/28/08dhb

Reg. No. 1 Decedent's Name (First Middle, Last) 2. Date of Death Day **Physician** Holland Ragan Nigh Januarv 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington County Washington County Hospital Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Hours 214-09-2291 99 4 1909 Director Jan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City. Town or Location 10b. County r 28a-f sh Maryland | Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 3 307 Garllinger Ave. 21740 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior grinder Truck Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever Frank Clayton Nigh Harriett Louise Metz ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Barger - daughter 11537 Englewood Road Hagerstown Maryland 21740 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Jan 10 2008 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home aitten 1331 Eastern Blvd. N. Hagerstown Maryland 21742 r implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line. 23a. Part1. Enter the dis 4 shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Respirator /Medical Due to (or as a consequence Examiner AL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 600 performe certificate 25. Was case referred to medical examiner?
1 ☐ res 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Matural

12/28/2007

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10:21 A M

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 Nes 2 No

Maryland

White

To the Hospital or Attending Physician: within 24 hours after deam.

To the Funeral Director: After thin SH-10

2 Accident

4 Homicide

(Check only one)

29a Certifier

Medical

Suicide

6 ☐ Could not be

determined

N62588 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 E. Antietam St. Hagerstown, rd JUDITIT MBAOUAIND 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

Unknown/

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tyes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

2 😾 No

Subject fell

Ave., Hagerstown, MD

Location (Street and Number or Rural Route Number, City or Town, State) 307 Garllinger

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 5 2008 Jackie Eugene Neely 10:48 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 8. Date of Birth Sept 7 1940 6 Sex If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 361-32-7521 Days Hours Min. 1 ★M 2 ☐ F 67 Ilimois Director Usual Residence of Decedent death with the Maryland Calvert 10c. City, Town or Location St. Leonard 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at Mary Land 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3950 Ramsey Hodges Road 20685 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11 Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or lte Inlury or other traumatic event, the Medical Examine. 1 Never Married 2 Married altimore, Maryland 21215-0036 1958-1962 1 ☐ Yes 2X No Specify: white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction general contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Neely Hazel Smith ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3950 Ransey Hodges Rd. St. Leonard, MD 20685 19a. Informant's Name/Relationship (Type. Print) Kathleen Neely- wife 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Nature of Methopolishing Punctual Service Jan 7 2008 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Alexandria Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Month disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner nalignanc-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 9☐Unknown signed by the and be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Carilleinger alhi 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dRw 9+1

Registrar
DHMH 17 Rev 1/2001

William

31. Date filed (Month, Day,

100 Hespita

32. Registra Signature

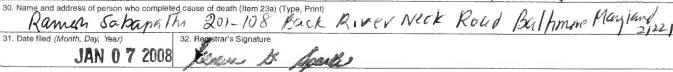
2008

The Frederick MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 **Physician** ANNE F. PIERCE 905PM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ellicott City Nursing&Rehabilitation Ellicott City Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours 7*/24/*1915′ Pennsylvania 070-03-7928 Director 92 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f show notified at Director 1 ☐ Yes 2 No Md. Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? ms 23a or ? 5216 Hillmont Ct. 21043 Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes A No Specify <u>ک</u> Specify.White 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12yrs Dental Hygentist Dental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown ဂ္ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5216 Hillmont Ct. Ellicott City, Md. 21043 W.Norman Pierce/son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ardent Crematory 1/6/2008 Hanover, Md. 21. Signature of Funeral Service 22. Name and Address of Facilit Harry H. Witzke's Family F. H. Inc. MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician throsok /Medical Due to (or as a consequence of): Examiner Advancey Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signature 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 | Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 1 Tyes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

az

State Registrar 31. Date filed (Month, Day, Year) JAN 07 2008



D 30641

January 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Helen Marie Porter 2008 10:35P /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing Home Frederick Walkersville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 ₩ F 217-12-2352 Director May 21 1920 Brunswick, MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Exeminer must be notified at MD Director Montgomery Germantown 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 18904 McFarlin Drive 20874 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ⅓ No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 No Specify Specify: White \$ 3 € Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within 72 h 16b. Kind of Business/Industry than ' Elementary/Secondary (0-12) College (1-4or 5+) the 10 Housewife Homemaker l 2 should be filed w h and Mental Hygier ' Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wesley Derflinger Grace Ault 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Brenda Cox, Daughter 18904 McFarlin Drive, Germantown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition permit. Pages 1 Department of H Important: If Itel any Injury or oth 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 Domation 5 Other (Specify) Rosedale Cemetery 1/7/2008 Martinsburg, WV neral Service Licerisee 21. Signa 22. Name and Address of Facility John T. Williams Funeral Home Wullan Barbara A. Williams, Owner 100 Petersville Road, Brunswick, MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a chaine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ines /Medical Due to (or as Consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed burial-trar Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE esn If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3□Ectopic pregnancy or in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2D No 1 Tes 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2: autopsy The certificate performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

al or Attending F Funeral Director: Hospital 24 hours To the To the within

DHMH 17 Rev 1/2001

State Registrar

Medical

4 Homicide

(Check only one)

29b. Signature and title of cer

30 Name and address of ne

29a. Certifier

>0 N 32 Registrar's Signature iled (Month, Day, Year) JAN 0 7 2008

and manner stated.

leted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Jew 10

State Registrar 31. Date filed (Month, Day, Year)

JAN

32. Registrans Signature

008

ELIZABETHA. GRIGHTUS, CANCERRESEARCH BUILDING ROOM 186 1650 CRLEANS STREET, BALTILLORE, MAMYLAND 21231

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month WILLIAM ARTHUR 12:40 PM 05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY COLUMBIA SENGRAL HISPITA TOWARD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 9,1922 6 Sex Birthplace (State or Foreign Country)
_ **Funeral** 7. Age (In vrs. last birthday) Days Hours 1**X** M 2 □ F Director 138 18 0893 85 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5647 Thelo Garth 21045 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ☐Yes 2⊠ No Yes, Give 'ear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Owner Service Master 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Robert Reese Ethel Charlotte Seemiller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5647 Thelo Garth Columbia, MD 21045 Katherine V. Reese/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 1-12-2008 Brentwood, MD 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** FALLINE RESPIRATIONY 33 DAYS /Medical Due to (or as a consequence of): **Examiner** Chronic USSTILUCTIVE PHYNOMARY DIGHASZ SYEMAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HART FATURE CONGESTIVE 1 Pres 2 No 3 Trobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 36974 01/05/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 UTTLE PATIKENT PARKWAY Corumsia MD 21044 DAVID O. NYANDENN MS 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State JAN 07 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

Takoma Park,

Md.

20912

7701 Carroll Avenue,

gistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Nasreen Kango, M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 1, 2008 20:20P M Laura Shupe Sexton January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 301 West Main Street Rising Sun Cecil If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months 1 □ M 2 🛛 F Days Hours 228-07-8185 86 Aug. 10, 1921 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 W. Main Street USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc.

1 ☐ Yes 2 🔀 No

16a. Decedent's Usual Occupation

Seamstress

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Interest the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Immediate Cause (Final)

3 ☐ Ectopic pregnancy

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

5 ☐ Other (specify)

perlension

ementia

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Specify.

506 Wise Road, Delta, PA 17314

R. T. Foard Funeral Home, P.A.

18. Mother's Name (First, Middle, Maiden Surname)

Celie Jane Tester

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

(Give kind of work done during most of working life. DO NOT use retired)

Calvary Baptist Cem. 1-5-2008

22. Name and Address of Facility

White

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy perform 2 No

1□ Yes

Other: 4 Nursing Home 5 X Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

118 North St Swite 38, Elbon MD21921

1 Yes 2 No 3 Probably 4 dinknown

Rising Sun, Maryland

Approximate Interval Between Onset and Death

Year

nears

Sewing Factory

1 ☐ Yes 2 K No If Yes, Give Year or Dates:

College (1-4or 5+)

Due to (or

Dire to for an a cone

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. S. SACHDEU MD 118 North

9□Unknown

4□Pregnant at time of death

Due to (or as a consequence of

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural" or Items 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at Maryland 21215-0036 Baltimore. **Physician** /Medical Examiner The law requires that the death certificate be executed burial-trar and Division or Vital Records, P.O. Box 68760 as the l use for be detached , page 2 should funeral director. this

Physician

/Medical

Examiner

10a. State

1 ☐ Never Married 2 ☐ Married

15. Decedent's Education (Specify only highest grade completed)

3X Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

8

20a. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immoduate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

17. Father's Name (First, Middle, Last)

21. Signature of Funeral Service License

James Henderson Shupe

19a. Informant's Name/Relationship (Type. Print)

Cathy Fanus/Granddaughter

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

<u>ک</u>

Completed

Be

Certification: To

Medical

State Registrar

After

24 hours after death Funeral Director: filled in by the

within 2

Hospital or Attending

IF FEMALE

Funeral

Director

		For	State of	of Marylan	•	artment of H		and Mei	ntal Hygi	ene			
		State Registrar			Cei	tificate of L	Death			g. No. 2	08	n L	016
Physicia		Decedent's Name (First, Middle RICHA		LIAM S	ОНМ				Date of Death Month anuary	Day	Year 08	3.4 me of 3:20	A M
/Medic Examin		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City, Town, or	Location o			4c. County			
		Frederick Men	orial Hos	spital		Freder	cick			Fre	deric	k	
Funeral		5. Social Security Number	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day,	Year)	9. Birthp	lace (State o	r Foreign
Director		346-34-5977	TIMEN ZUF	62	Yrs.				ig. 21,		I11i	nois	
and and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside Ci	ty Limits
Marylan f show ied at	ō	Marvland Fred	erick		E 0	J J - 1-						1 ⊠Yes	2□No
the M	Director	10e. Street and Number	erick		rre	derick 10f. Zip Code			10	g. Citizen of	What Cour	ntry?	
3a ol		1748 Heather	Lane			2170	12			Unit	ed S	tatas	
deat	Funeral	11. Marital Status		cedent Ever in U.	S. 13.	Was Decedent of H f Yes, specify Cuba		gin? (Specif	y Yes or No-	14. Rad	e - Americ	an Indian,	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show alcal Examiner must be notified at		1 ☐ Never Married 2 🖾 Marr	ied 1⊠Yes	2 □ No		1 ☐ Yes 2 ☑ No	Specify:		un, etc./	Specif		ite	
hours tural	d by	3 Widowed 4 Divorced		Dates: Vietn		dent's Usual Occup	ation					el co ém c	_
n 72 "nat	Completed	(Specify only highe	1		(Give	kind of work done of DO NOT use retired	durina most	t of working		l6b. Kind of B	usiness/in	dustry	
with iane. thar	E O	Elementary/Secondary (0-12)	College 4	(1-4or 5+)	Fed	eral Mana	oe r			Dept.	of t	he Arm	v
offled other	Be C	17. Father's Name (First, Middle,				oraz namo		er's Name <i>(F</i>	irst, Middle, N			112.11	<i></i>
uld be Menta rked tic ev	To B	William B. Sol	ım				Mil	ldred	I. Def:	fenbaug	gh		
Pages 1 and 2 should be filed within 72 ho nent of Health and Mental Hygiane. Int: If Item 27 Is marked other than "natur iny or othar traumatic event, the Medical.		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural F	loute Number,	City or Town	State, Zip	Code)	
and lealth m 27		Patricia R. Sc	hm / Wife			Heather	Lane		derick				
ges 1		20a. Method of Disposition 1 Burial 2 □ Cremation	3 □Removal from	State C	emetery, crei	sition (Name of matory or other plac	i 1	Janua:	cy .	20c. Location	- City or To	own, State	
t. Pa rtmen rtant: njury		4 Donation 5 Other (S		St.	. John	s Cemete	ry	7, 200	08 F	'rederi	ck, N	larylar	nd
permit. Pages Department of Important: If it any injury or o		21. Signature of Flunaral Service	Licensee		16	2. Name and Addres	ımtowi	^y Stau n Pike	ffer Fred	uneral erick,	Home Mary	s, P.A land 2	21702
36.3		23a. Part1. Enter the dise se, or shock, or heart failure.	complications that only one cause on	caused the death	n. Do not ent	er the mode of dyin	g, such as	cardiac or re	espiratory arre	est,		Approximat Interval Bet	ween
Physician		Immediate Cause (Final disease or condition	Cas	rectini	= /K	of Fa	ilen	2				Onset and	Death DC
/Medical Examiner		resulting in death)	Due to	as a consequ	uence of):							200	
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	wence of	0515						39~	2
nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	\$	(or do d corrocq:	201100 01).							Ť	
be executed sician and burial-transit	Exa	resulting in death) Last	C. Due to	(or as a consequ	uence of):								
ate be hysicia the bur	dical		d										
rtifica ng ph as th	Vedi	IF FEMALE:	1										
eath certific attending p for use as t	an/h	23b. Was decedent pregnant in the past 12 months?		utcome pf pregna birth 2□Feta		∃Ectopic pregnancy	,				ite of deliv	•	Year
The law requires that the death certificate ta has been signed by the attending phys bage 2 should be detached for use as the	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	nant at time of denomination	eath 5	Other (specify)				IVI	ontri	Day	real
s that the de ned by tha		Part II. Other significant conditi	ons contributing to	death but not resu	ultina in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use con	tribute to t	he cause of	feath?
w requires to been signer should be considered.	d by		= melli		9	,g g			1 □ Y∈	\ <u>/</u>		ably 4 🔲	
w req	ete								24a. Was ai	24h	Were aut	psy findings	availablo
ha la a has	Completed								autops perforn	y ned?	prior to co death?	mpletion of a	ause of
	Be Co	25. Was case referred to medica	1				26 Place	e of Death ((1□ Yes 2 Check only on	e)	1 ☐ Yes	2 V No	
hysician: Tha la his cartificata ha I director, page 2	0	examiner? 1 ☐ Yes 2 ☐ 💢	Hospital:	Inpatient 2	ER/Outpaties	nt 3 DOA Oth	er.		5 ☐ Reside		her (Speci	fy)	
2 = 0	n: T	27. Manner of Death Natural 5 ☐ Pendir	/8.4	e of Injury onth, Day Year)	28b. Time o	f 28c. Injur Wor	y at k?	280	d. Describe ho	w injury occu	rred		
tendil eath. tor: A tha fu	catic	2 Accident investi	gation				Yes 2 □ I						
lor At after d Direct	Certification:	4 Homicide determ	nined 28e. Plac	e of injury - At ho ding, etc. (Specif		eet, factory, office		28f	Location (St. City or Town		ber or Run	al Route Nun	nber,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cartification properties of the funeral director.		(Check only ∠ Medical	ng Physician: To the Examiner: On the	basis of examina	wledge, deat	h occurred at the tir vestigation, in my o	ne, date an	nd place, and ath occurred	d due to the ca	ause(s) and mate and place	anner as s	stated.	s)
o the lithin 2 o the lomplet	Medical	29b. Signature and title of certific		nner stated.		29c. Licens			2	9d. Date/signe	ed / (Month.	Dav. Year)	
F 3 F 8		* XIRI	fart	non	~	1 D	-/3	397		3 / . C	08		
W/II.		30. Name and address of person	who completed case	use of death (Item	n 23a) (Type,					1 . 6	00		
12,		Robert L. Kau	fmann. M	D. 30	OW. N	ineth Str	eet	Frede	rick, l	Marylar	nd 21	701	
Sta Registr		31. Date filed (Month, Day, Year, JAN, 0 7	2008	Registrar's Signa	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ROBERT EARLE SHRINER /Medical 2008 3:18 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Jan . 8 , Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 → M 2 □ F 214-34-9909 70 Jan. 1937 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1. Yes 2 No Director Maryland | Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 37 Water Street 21788 U.S.A. within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 should be filed w h and Mental Hygiei 7 is marked other th Road Maintenance State Highway Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ev Maurice Edward Shriner Ellen May Reifsnider 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane R. Shriner / Wife 37 Water Street, Thurmont, Maryland 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🏅 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 1/4/08 Smithsburg, Maryland 21. Signature of Full of Service Lice 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. John 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part 1. Enter the disease, or complications the cause the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MINOXIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 → 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 - H 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury 1 Tyes 2 No 2 Accident

P.O. Box 68760 Division or Vital Records,

Baltimore, Maryland 21215-0036

death. after death filled in by the Hospital or To the Hospital within 24 hours a To the Funeral C

DHMH 17 Rev 1/2001

State Registrar

Medical

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

00052950

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 200 8

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Lamont C. Smith, 400 West 7th Street, Frederick, Maryland 21701 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2008 1:15 P M John Franklin Shockley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2□F 73 215-38-7721 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f ehow traumatic avant, the Medical Examinar must be notified at 1 TYes 2000No Directo Berlin Worcester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9817 Pitts Rd. 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: If Yes, Give Year or Dates: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hotel 12 Security Guard 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be 1 and Mental I Hester Lecates John H. Shockley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9817 Pitts Rd., Berlin, MD 21811 Ruth Shockley / wife of Heelth Itsm 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ott 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/8/2008 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Parf I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Throsdestic Cardiovarales Discare Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine ete hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): 260% 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) o 9 Unknown S P P. O S Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Drinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificete hes 2 5 No 1 Yes 772/ Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 ☐ Yes PANo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Lapatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 215 38 Division 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation efter death Director: 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ŏ To the Hospital c within 24 hours of To the Funstel D completely filled i

State Registrar

(50 rodulia, CD Wichdos 31. Date filed (Month, Day, Year) JAN 07 2008

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

32 Registrar's Signature

Coastal Hylmy Tunck Island, De 19944

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 5008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Division or Vital Records, P.O. Box 68760,

within 24 hours a Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 040370 M_{I} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter L. Wisniewski, M.D. 110 H. Date filed (Month, Day, Year)

JAN Ú 7 2008 110 Hospital Road, Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 3, 2008 ear **Physician** 9:00 A M Arville Otto Stuart /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1170 Amber Way Owings Calvert County if Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**½** M 2 □ F 58 577-64-4283 Director Sept_17. Washington. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 7 is marked other than "natural" or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Calvert Chesapeake Beach 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3615 28th Street 20732 USA 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Foreman Public Electric Util. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Otto Stuart Edith Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) s 1 and 2 s of Health ar Donna Stuart (wife) Chesapeake Beach, MD 3615 28th Street 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan 7 permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stonewall Mem Grdns. Manassas, VA 21. Signat of uneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. Goff 8125 Southern Maryland Blvd. 20736 Owings. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE INEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BACTERIAL ENDOCARD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine certificate be executed burial-transit FTH ICILLIN that initiated events and resulting in death) Last Due to (or as a consequence of Box 68760 sician Physician/Medical attending physical for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 2 No o 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has autopsy perform certificate 2 4NO or Vital 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughter's Other: 4 Nursing Home 5 Residence 6 Nother (Specific Residence Hospital: 1 Tes 2 To No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Anatural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ai or Attending Patter death. After Certification: Division Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed oduse of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar John H. Weigel, M.D.

31. Date filed (Month, Day, Year)

dew 10

32. Registra & Signature

110 Hospital Road, Suite 310, Prince Frederick, MD 20678

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

JAN 0 7 2008

300 31. Date filed (Month, Day, Year) GIVY

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) 0

Please Type of Print in Black Indentitie ink! Pensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1/01/2008 Month Physician 1 ull 0610 Edward Dec hARLES 31, 200) /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rehab + Nursing Ctr. Wicomico If Under 24 Hrs lisburu 8. Date of Birth (Month, Day, Year) 8 - 13 - 1920 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs Jast bi **Funeral** Hours Months Days 218-20-6238 Director VirgiNiA Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f shov 1⊈Yes 2 No ns 23a or 28a-f sh must be notified Director SALISBURG Wicomico ARUJANU 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21804 LOCUS U5A 313 E. Items 23a Funeral death v 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black. White, etc. Pages 1 and 2 should be filed within 72 hours after a nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No "natural", or Specify: Specify: BOOK Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than NONE ABORER 05 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOWN UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SusiE FRIENC 21804 313 E SALS Item 27 MARYLANd Locus 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If It 1 Burial 2 □ Cremation 3 □ Removal from State ACRES 08 MORY HAND SAL; BOURY, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Salis. Ma WESTICA SIEWAR Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be execu ed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 □HNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 LNd 2 ER/Outpatient 3 DOA 1 ☐ Inpatient P this 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? ieral Director; After filled in by the funer Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

illiam

31. Date filed (Month, Day, Year) JAN 0 4

H.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robins

MiD

32. Registar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

 \mathcal{Q}

29c. License numbe

Ave. Salisburg

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	ryland		artment of H tificate of L		-	giene Reg. No. 0 0 (01023
	Physici	an	1. Decedent's Name (First, Middle, Las ELEANOR		AG	NEK	2		2. Date of De Month	Day Ye	3. Time of Death
5	/Medic Examir		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Dea	JANUA ath	4c. County of [
			BROOKE GROVE RE	NURS	11/4	-E.V.D.		YSPRIN			GOMERY
	Funeral Director		5. Social Security Number 6. S 578-40-1616	9x 7. Age □M 2⊠F	(In yrs. las	st birthday) Yrs.	Months Days	If Under 24 Hr Hours Mir		th 9. y, Year) 1914	Birthplace (State or Foreign Country) New York
	ס		Usual Residence of Decedent				1				
	Manyla f ahov	ō	10a. State 10b. County District of Columbia		ruc. City,	Town or Lo		t on			10d. Inside City Limits 1 Yes 2 No
	r 28a-	Director	10e. Street and Number				Washing	LOII		10g. Citizen of Wha	it Country?
	ath wit	ralD	5210 Kansas Aver	ue, NW				20011			I.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Itama 23e or 28e-f ahow amply figury or other traumatic avent, I'm Madical Examination must be notified at ance.	by Funeral	Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Endemed Forces? 1 ☐ Yes 2 ☒ Note of Yes, Give		1	Mas Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2점 No	spanic Origin? (n, Mexican, Pue Specity:	(Specify Yes or No arto Rican, etc.)		American Indian, White, etc.
21215-0036	2 hour	ted t	15. Decedent's Ed	Year or Dates: ucation		16a. Deced	ient's Usual Occupa	ation		16b. Kind of Busin	White ess/industry
215	ithin 7.	Completed	(Specify only highest gra	de completed) College (1-4or 5+		life. L	kind of work done of DO NOT use retired)			
2	filed w Hygier ther th		12 17. Father's Name (First, Middle, Last)			Executi	ive Secreta			United Sta Maiden Sumame)	ites Government
Maryland	id be fental rked o	To Be	Joseph Matthew	Wagner					eanor Barba		
lary	2 shou and N is man	_	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ng Address (Street a	and Number or h	Rural Route Numbe	er, City or Town, Sta	te, Zip Code)
e, ≥	1 and Heelth nm 27 ther tr		Richard F. Wagner -	Nephew	20h Pla		L1 Dove Driv	ve, Bel A	lton, Maryl Date	Land 20611 20c. Location - Cit	v or Town State
Baltimore,	ages ent of nt: #f it ny or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cen	netery, cren	natory or other place Cemetery		07/2008		d, Maryland
alti	Departme Departme Importer any injur		21. Signature of Funeral Service Licen	søre -	Cede	22	. Name and Addres	s of Facility			u, haryrand
<u> </u>	8 3 5 8		· Umanda	Ludewig		11		mpshire A	venue, Silv	ver Spring,	Maryland 20904
1	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line).	Do not ento RAブ		g, such as cardi	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque		nnnin	/T11 / /	מו		NAVE
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	conseque	nce of):	ARRHY				IDN 13
	acuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· COK	SON	ARY	/ AR-	TERY	DISEA	SE	YEARS
8760,	cate be executed physician and the burial-transit	al E	Tooland in doubly East	Due to (or as a	conseque	nce of):					
687	ificate g phys as the	edical		d						1	
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours elfer death. You har Funeral Director: After this certificate has been signed by the eltending prompletely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal d	eath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	l delivery Day Year
σ.	thet the	y Ph	Part II. Other significant conditions of	ontributing to death but	not resulti	ing in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use contribu	ite to the cause of death?
rds	w requires been sign should be	ed b	CONGESTIVE	HEART F	AIL	URE	DISLIP	IDEMI	A 10'	Yes 2□No 3[Probably 4 Unknown
Division of Vital Records,	e taw re has be	Completed	DEMENTIA	DEPRE	5511	DN			24a. Was	osy prior	e autopsy findings available
<u>a</u>	in: Th ilicate or, pag		25. Was case referred to medical						1 Yes	- N	Yes 2 No
<u>=</u>	yalcie is cert direct	To Be	examiner?	Hospital:	2 DEF	P/Outpatien	t 3 DOA Othe		eath (Check only of Home 5 Resid	one) dence 6 □Other (Specify)
0	ing Pt Mer th uneral	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	28c. Injury Work	at ?		now injury occurred	
isio	Attend death ctor: / y the f	Certification:	2 Accident investigation 3 Suicide 6 Could not be		v - At hom	e. larm. stre		res 2 □ No	28L Location (Street and Number o	or Rural Route Number,
2	s effer s effer ni Dira ad in b	Certi	4 Homicide determined	building, etc.	(Specify)	,,	201, 120101 y, 011100		City or Tov		, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attanding Physician: The law within 24 hours effer death. To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2	edical ((Check only 2 Medical Exam	vsician: To the best of iner: On the basis of e	xaminatio	edge, death n and/or inv	occurred at the time	e, date and place	ce, and due to the curred at the time.	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	o the lithin 2 o the lo the lo the lomplet	Med	29b. Signaty/ and title of certifier	and manner state	ed.		29c. License			29d. Date signed (A	
i	5 - 3 - 8		Sargetas	unde M	. (),						2,2008
- (-			30. Name and ad ress of person who o				Print)				
			SANGEETA SIM 31. Date filed (Month, Day, Year)	LOTE, MD			LANDW	OOD CT	5. #105	OLIVE	1 MD 20833
	Sta Registr	-	IAM D. A. 20	18 January	Jugiratur	h	anti s				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death Day **Physician** Year ames 22:30 PM Jan 19 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St Agnes
5. Social Security Number Hospital Baltimore, MD 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | Month | Day | Month | M Birthplace (State or Foreign Country) **Funeral** 1**☑**M 2□F Months Days 216-01-361 Director Usual Residence of Deceden 10b. County 10c. City, Town or Location if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Baltimore 1 Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 21225 USA Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces'
1 M Yes 2 ☐
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) dary (0-12) College (1-4or 5+) embly 17. Father's Name (First, Middle, Last) UNK 2 should be fi and Mental H Be ို 19a, Informant's Name/Relationship (Type. Print) Harry Allen (Son 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code, 20a. Method of Disposition permit. Pages Department of Himportant: If Ite any Injury or ot 2-☐Cremation 3 ☐Removal from State nownsuille, mD *now* noville 5 ☐ Other (Specify) e of Funeral Prvice Licensee 21. Signs 5151 bollimore Nat 1 Pilce sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acure Renal failure 1 day /Medical Due to (or as a consequence of): flash pulmfailure and Examiner Congestive heart I day -onary edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Ischemic ardiom physician and is the burial-trans years Physician/Medical attending ph d for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Ö 9□Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Hibrillanon Arrial 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed yper tension 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Jas autopsy performed page certificate Vital 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No မ 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division (Month, Day Year) 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P 20965 2008 Jan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST ALNES HOSPITAL. 9005 CATON AVENUE, BALTIMORE, MD BODDU NEERAJA. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 Registrar De Ball & Bull

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

Physic		State of Maryland / 1-For State Registrar	Certificate of	Death	R	eg. No. 201	18 DIA		
ical Exam		Decedent's Name (First, Middle,Last)			2. Date of Dea Month January 1	th Day Year	3. Time of Death 2339 hrs		
		CLARENCE ANDERSON 4a. Facility Name (if not institution, give street and number)	41	b. City, Town, or Location of D		4c. County of Deatl			
		11 West 20th Street Apt. 17 M		Baltimore		N/A			
Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 X M 2 F	(In yrs. last birthday) 43 Yrs.	If Under 1 Year If Under 2 Months Days Hours	4Hrs. 8. Date of Bi Min. 07/15	th(MM/DD/YYYY) 9. Bir Forei /1964	thplace (State or Indianal State or Indiana State or Indianal State or Indiana State or Ind		
any		Usual Residence of Decedent 10a. State 10b. County 1			10d. Inside City Limits				
*	_	MARYLAND N/A	Oc. City, Town or Location BALTIMO			1 X Yes			
Maryland 28a-f show 3 at once	Director	10e. Street and Number	BABITMO	10f. Zip Code	1	0g. Citizen of What Cou	ntry?		
h the N 3a or	直	1656 BRUCE COURT		21217		U.S.A.			
after death with the Maryland al", or items 23a or 28a-f she iner must be notified at once	neral	11. Marital Status 1 X Never Married 2 Married Armed Forces?		Decedent of Hispanic Origin s, specify Cuban, Mexican, P		- 14. Race - Amer White, etc.	ican Indian, Black,		
		1 Yes 2	X No	Yes 2 X No specify:		Specify: B	LACK		
ours af stural' amine	d by	or Dates: 15. Decedent's Education (Specify only highest grade comp	leted) 16a. Decedent	's Usual Occupation (Give kin		16b. Kind of Business			
o 172 ho nan "ina cal Ex	lete	Elementary/Secondary (0-12) College (1-4 or 5+	during mo	st of working life. DO NOT us	e retired)				
LLLIS-0030 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	11th grade 1 17. Father's Name (First, Middle, Last)	LABO:		Mana (First Middle	SELF			
e filed al Hyg ced off	Be C	PAYTON S. ANDERSON			Name (First, Middle, ES G. KYL)				
ould b I Meni s mari	일	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and Number			e, Zip Code)		
id 2 sho ilth and m 27 is aumati		Payton Anderson Sr./Father		Bruce Ct., Ba					
Department of Hea Important: If iten injury or other tra		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State		tion (Name of cemetery, er place)	Date	20c. Location - City o	Town, State		
Page ment tant: or ot		4 Donation 5 Other Specify:	METRO CREI		01-21-08	BALTIMORE	, MARYLAND		
permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21 Schature of Funeral Service Live see	WII 12	ame and Address of Facility LLIAM C BROWN 06 W NORTH AV	ENUE		OME P.A.		
hysician		23a. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.	e mode of dying, such as card	diac or respiratory ar	rest, shock, or heart	Approximate Interva Between Onset and			
/Medical caminer		Immediate Cause (Final disease or condition resulting in death) a. Complication Due to (or as a consequence)		immune deficienc	y syndrome		Death		
		Sequentially list conditions, b	defide ory.						
	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
=	T wax								
ecuted and trans									
ate be executed hysician and e burial - transit	edic	x UNPENDED AMENDED #Z3a,27,per	ME,g876, 2/2/C)/08_TT					
the attending phy	Physician/Medical	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the	e of pregnancy	al death 3 Ectopic p	regnancy	23d. Date of delive Month	ry Day Year		
death cer the attendi	sicia	past 12 months? 1 Yes 2 No 9 Unknown	me of death 5 Oth	er (Specify)					
de de	Phy	Part II. Other significant conditions contributing to death t	but not resulting in the ur	oderlying cause given in Part	23e Did 1	obacco use contribute to	the cause of death?		
the d by the ched	þ	3	and the control of th	aconymig cadoo given iii i are	,	s 2 No 3 Pro			
es that the igned by the e detached					24a. Was		utopsy findings availabl		
requires that the coeen signed by the could be detached	etec								
e law requires that the le has been signed by th ge 2 should be detached	mpletec					ormed? death?	completion of cause of		
The law requires that it cate has been signed by page 2 should be detach	1	25. Was case referred to medical		26.Place of Death (C	perfo 1 ✔ Yes				
ysician: The law requires that the chis certificate has been signed by th director, page 2 should be detached	Be C	examiner? Hospital:	t 2 ER/Outpatient	26.Place of Death (C	perfo 1 ✔ Yes	ormed? death?	es 2 No		
ing Physician: The law requires that the c After this certificate has been signed by th uneral director, page 2 should be detached	To Be C	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month Day Yea		3 DOA Other 1 I	perfo 1 ✓ Yes heck only one) Nursing Home 5	ormed? death? 2 No 1 V	es 2 No		
vtending Physician: death. ctor: After this certifi y the funeral director,	To Be C	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year	28b. Time of In	3 DOA Other4 N jury 28c. Injury at Work?	neck only one) Nursing Home 5 28d. Describe	Residence 6 Other	res 2 No		
death. ctor: After this certifi y the funeral director,	To Be C	examiner? 1 Yes 2 No 1. Accident 3 Suicide 2 No Hospital: 1 Inpatient 2 Pending Investigation 28a. Date of Injury (Month, Day, Yea) 28b. Place of Injury (Month, Day, Yea) 28b. Place of Injury (Month, Day, Yea)	28b. Time of In	3 DOA Other 1 I	neck only one) Nursing Home 5 28d. Describe	Residence 6 Other how injury occurred	res 2 No		
ottending Physician: death. ctor: After this certifi y the funeral director,	Certification: To Be C	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 29a. Certifier Could not be determined 29a. Certifier Could not be determined 29a. Certifier Could not be determined	28b. Time of In	3 DOA Other ₄ N jury 28c. Injury at Work? 1 Yes 2 N t, factory, office building, etc.	perfo 1 ✓ Yes heck only one) Nursing Home 5 28d. Describe o 28f. Location or Town,	Residence 6 Other how injury occurred Street and Number or R State)	er: Scene ural Route Number, City		
ttending Physician: death. ctor: After this certifi y the funeral director,	Certification: To Be C	examiner? 1. Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examiner:	28b. Time of In	3 DOA Other, 1 Nother, 2 Nother, 2 Nother, 2 Noth, factory, office building, etc.	neck only one) Nursing Home 5 28d. Describe 28f. Location or Town,	Residence 6 Other how injury occurred Street and Number or R State) se(s) and manner as sta	res 2 No Per: Scene ural Route Number, City ted.		
Attending Physician: r death. rector: After this certifi by the funeral director,	ertification: To Be C	examiner? 1. Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check pm) 1 Certifying Physician: To the best of my livering the control of the period of the control of the c	28b. Time of In	3 DOA Other, 1 Nother, 2 Nother, 2 Nother, 2 Noth, factory, office building, etc.	neck only one) Nursing Home 5 28d. Describe 28f. Location or Town,	Residence 6 Other how injury occurred Street and Number or R State) se(s) and manner as sta	res 2 No Per: Scene ural Route Number, City ted. he cause(s)		
trending Physician: death. ctor: After this certifi y the funeral director,	edical Certification: To Be C	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my I one) 2 Medical Examiner: On the basis of examinand manner stated.	28b. Time of In	3 DOA Other 1 Nother 2 Nother 3 Nother 3 Nother 4 Nother 4 Nother 5 Nother	neck only one) Nursing Home 5 28d. Describe 28f. Location or Town,	Residence 6 Other Now injury occurred Street and Number or R State) se(s) and manner as state and place, and due to the state of the	r: Scene ural Route Number, City ted. he cause(s) onth, Day, Year)		
ottending Physician: death. ctor: After this certifi y the funeral director,	edical Certification: To Be C	examiner? 1 Yes 2 No 1 Nanner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated. 29b. Signature and title of certifier Mana Alane Alane Alane 30. Name and address of person who completed cause of dea	28b. Time of In arry - At home, farm, street knowledge, death occurre ination and/or investigation	3 DOA Other4 Norther4	neck only one) Nursing Home 5 28d. Describe 28f. Location or Town, e, and due to the caurred at the time, date	Residence 6 Other No 1 Other No injury occurred Street and Number or R State) se(s) and manner as state and place, and due to t 29d. Date signed (M.	er: Scene ural Route Number, City ted. he cause(s) onth, Day, Year)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical Certification: To Be C	examiner? 1 Yes 2 No 1 Nanner of Death 1 Natural 5 Pending	28b. Time of In	3 DOA Other 1 Nother 2 Nother 3 Nother 3 Nother 4 Nother 5 Nother 4 Nother 5 Nother	neck only one) Nursing Home 5 28d. Describe 28f. Location or Town, e, and due to the caurred at the time, date	Residence 6 Other No 1 Other No injury occurred Street and Number or R State) se(s) and manner as state and place, and due to t 29d. Date signed (M.	er: Scene ural Route Number, City ted. he cause(s) onth, Day, Year)		

OCME

			For	State of Ma	arylan				and Me	ental Hy	giene	0.0.0	01026
			1 - State Registrar			Cei	rtificate of L	Death			Reg. No.	UUU	01026
	Physici	an	Decedent's Name (First, Middle, Last	st)					2	Date of Dea Month	ath Day	Year	3. Time of Death
	/Medi			kins, Sr.					_	January		2008	10:05 A ^M
)	Examir	ner	4a. Facility Name (If not institution, give				4b. City, Town, or	Location o	f Death			ounty of Death	
			Laurel Regional 5. Social Security Number 6. S		. (In ure	last birthday)	Laurel If Under 1 Year	If Under 2	24 Hrs To	3. Date of Birt		nce Ge	
	Funeral Director			M 2□F	81	Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year)	Coui	**
А.			Usual Residence of Decedent						1	eb. 12	2, 192	26 Vir	ginia
	ylanc ylanc		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	a-f sl	ctor	MD Prince (George's]	Laurel							1 □Yes 2√□No
	th th	Director	10e. Street and Number				10f. Zip Code				10g. Citizer	n of What Coul	ntry?
	23a ust b		14709 Bowie Road	1, #102			207					USA	
	tems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig in, Mexican	gin? (Spec i, Puerto R	ify Yes or No- ican, etc.)	- 14.	Race - Americ Black, White,	
30	hours after death with the Maryland tural", or Items 23a or 28a-f show al Examiner must be notified at	by F	1 ☐ Never Married 2 🔯 Mamed 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ю		1 □ Yes XXNo	Specify:			1		hite
21215-0036	hour tural	Pa Da	15. Decedent's Ed			16a Decer	dent's Usual Occupa	etion			16b Kind	of Business/In	duotne
ဂ်	in 72 "na" n	Completed	(Specify only highest gra	de completed)		(Give	kind of work done of DO NOT use retired	lurina most	of working	7	160. Kilid	oi business/in	dustry
7	with jene r than	E	Elementary/Secondary (0-12) 6th	College (1-4or 5	+)	Med	chanic	,			Z A	utomob	ile
	be filed within 72 hours after death with the Marylan tital Hyglene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (First, Middle,	Maiden Su	ırname)	
Jand		70 E	Dennis Atkir	ıs					Emm	na Baxt	er		
Mary	2 sho and h is ma	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street a	and Numbe	er or Rural	Route Numbe	er, City or T	own, State, Zip	Code)
e, ≅	r t 2 # rd		Edna M. Hamlet/Dau	ighter			Marton S	treet	, Lau	rel, N	1D 20	707	
	ges 1 a t of Hea if Item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Da	te	20c. Locat	tion - City or To	own, State
altimor	permit. Pages Department of Important: If It any Injury or o		4 □ Donation 5 □ Other (Specify		I I	y Hil	L Cemeter	y 1	/21/2	8008	Laure	l, MD	
g	ermit Depar Inpor		21. Signature of Funeral Service Licen				2. Name and Addres		DOM				me, P.A.
	⊕ □ = a o		G > G	_	10077		313 Talbo				-	207	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each lin	the deati ie.	n. Do not ent	er the mode of dyin	g, such as	cardiac or	respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)				cinoma Co	lon					
	Examiner			Due to (or as a	a consequ	uence of):							
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	a consequ	uence of):						-	
	uted d ansit	Examiner	Cause (Disease or injury that initiated events							1			
Ď	exec an an rial-tr	Exa	resulting in death) Last	Due to (or as	a conseq	uence of):							
0/00	certificate be executed iding physician and ise as the burial-transit	dical		d									
٥	ng ph as th	- Φ	IF FEMALE:										
X D	ath ce ttendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth			JEctopic pregnancy				230	d. Date of deliver	,
5	ician: The law requires that the death certificace has been signed by the attending I rector, page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡Unknown	time of d	eath 5□	Other (specify)					WORLD	Day Year
7.	that that the		Part II. Other significant conditions of	ontributing to death hi	ıt not resi	ulting in the u	nderlying cause give	en in Part I		23e Did to	nhacco use	contribute to t	he cause of death?
S,	signe d be	d by	Coronary Arter				and grade grade			101			pably 4 □Unknown
spiosa	v req been shoul	ompleted		y_Discuse									
ั้ง C	The law ate has b	E								24a. Was autop		prior to co death?	opsy findings available impletion of cause of
ומ	sician: The certificate har rector, page	ပို	25. Was case referred to medical					00 51	/D #	1□ Yes	2 🔯 No	1 ☐ Yes	2 X No
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatie	nt 2VCV	ER/Outpatien	t 3 DOA Othe	DF:		Check only o		☐Other (Specia	£.)
5	g Ph ter thi		27. Manner of Death	28a. Date of Injur	у	28b. Time of			T .	d. Describe f			(19)
2	arth. pr: Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	r rear)	Injury		c? Yes 2∐h	No				
<u>></u>	r Atte er de recto	Certification:	3 Suicide 6 Could not be determined	28e. Place of inju	ry - At ho	ome, farm, str	eet, factory, office		28	If. Location (S City or Tov		Number or Rura	al Route Number,
2	itai o rs aft rai Di led in	Č			(-)	,,			-	Ony or 101	m, oldie,		
	Hosp 24 hou Fune stely fil	Medical	29a. Certifier (Check only one) 1X Certifying Ph 2 Medicai Exam	ysician: To the best on niner: On the basis of	examina	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, ar th occurre	nd due to the d at the time,	cause(s) ar date and pl	nd manner as s lace, and due t	stated. o the cause(s)
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	and manner sta	ieu.		29c. License	number			29d. Date s	signed (Month,	Day, Year)
	->-0		· MIM	11/11/1			D100	220					
	~		30. Name and address of person who	completed cause of de	eath (Item	1 23a) (Type	D192	Z Z U			T/18	/2008	
L	· ·		Neil A. Meade	9811 Ma	,	,	•	el, MI	20	708			
	Sta		31. Date filed (Month, Day, Year)	32. Registra			18						
	Registr	ar	JAN 2 2 2008	1 1/25 820		Loca							

Registrar

0

State Registrar (Item 23a) (Type, Print)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H			giene Reg. No.	008	01029	
. 100	Physici /Medic		1. Decedent's Name (First, Middle, La: Chamara Q. Ashb					2. Date of De Month Janua :	Day	2008	3. Time of Death 2:03pm M	
	Examir		4a. Facility Name (If not institution, given Johns Hopkins Ho		er)		Baltimor	re		unty of Death	N/A	
	Funeral Director			ex 7. □M 2 ∑ F	Age (In yrs. last birthday 6 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi			9. Birth	olece (State or Foreign ntry) MD	
	Maryland f ahow	tor	Usual Residence of Decedent 10a. State 10b. County 10b Balti	more	10c. City, Town or L		n Oak				10d. Inside City Limits 1 ☐ Yes 2℃¥lo	
	I within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f ahow tha Miodical Exercitive mask by molified at	i Director	10e. Street and Number 11 King James Ci	rcle	le 101. Zip Code 21207					10g. Citizen of What Country? UNited States		
980		by Funeral	11. Marital Status 1 💆 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	12. Was Decede Armed Force 1 Tes 2 ff Yes, Give Year or Date	Σ.Κ.∘	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		Race - Ameri Black, White, ecify:		
21215-0036		Completed	15. Decedent's E. (Specify only highest gra	ducation de completed) College (1-40	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired n/a	ation during most of w	working		of Business/Ir	dustry	
Maryland 2	be filed tal Hyg d othe event.	To Be C	17. Father's Name (First, Middle, Last) Unk.					lame (First, Middle, ey M. Brud		mame)		
	nd 2 shulth and 27 is m		19a. Informant's Name/Relationship (Stacey M. Bruce			ing Address (Street King Jame						
Baltimore,	Pages 1 and ment of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify)		20b. Place of Disp cemetery cre HOLY Cro	osition (Name of matory or other place DSS CEMETE	ery Jan	uary 21,		ion - City or T altimo:		
Balt	permit. Pag Department Important: I any injury o		21. Signatul of Furer Source	Victor I	P. Dođa,Jr.	2. Name and Addre harles L. 501 E. Fo	ss of Facility Steven ort Ave,	s Funera Baltimo	l Home ce MD	Inc. 21230	The state of the s	
\$5°	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finaf disease or condition resulting in death)	plications that causone cause on each Termina	sed the death. Do not en h fine. al Cardiac I	iter the mode of dyin	g, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death 1 hour	
€.	/Medical Examiner			Respira		2 hours						
V	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or Altered		6 years						
8760,	cate be exe physician a the burial	cal	resulting in death) Last		as a consequence of): Development			6 years				
.O. Box 6	The law requires that the death certificate be executed tie has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2XX90 9 Unknown		n 2 ☐ Fetal death 3 t at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>			23d.	. Date of deliv	ery Day Year	
Q.	quires that n signed by old be deta	þ	Part ff. Other significant conditions of	ontributing to deat	h but not resulting in the	underlying cause giv	en in Part I.		obacco use o		he cause of death?	
I Records,		Completed						24a. Was auto perio 1 Yes	psy ormed?	prior to co death?	opsy findings available impletion of cause of	
Vital	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		ont 3 DOA Oth		Death (Check only o				
of		ation: To	1 Yes 2CNo 27. Manner of Death 12CNatural 5 Pending 2 Accident investigation	28a. Date of I (Month,		of 28c. Injun Wor	4 C INGISITY	Home 5 Resi 28d. Describe			(y)	
Division	at or Attending s after death. Il Director: Alter od in by the fune	Certification;	3 Suicide 6 Could not be determined	OP 280 Bloom of legistry. At home form street feelers office.						umber or Run	al Route Number,	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in the Funeral Director of the Funeral Dire	edical (est of my knowledge, dea s of examination and/or i stated.							
)	Within To the comp	ž	29b. Signature and title of certifier	.b		29c. Licens				igned (Month, ary 18	• • • • • • • • • • • • • • • • • • • •	
•	h		30. Name and address of person who	completed cause of	f death (Item 23a) (Type	Print) life Street	ct. Ba	ltimore	MO 2	21287		
Ž,	Sta Registr		31. Date filed (Monito Day, Year)	32. Regi	istrar's Signature	2346						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Voar **Physician** 6:00PM ANHARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SECOURS MORE If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** Days 1 M 2 □ F Months Hours 214-20-7489 May 9, Director 1925 VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notifled 1 ☐Yes 2 ☐ No MD Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1825 Ramsey Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc регтіt. Pages 1 and 2 should be filed within 72 hours after о Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Labor Worker Manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earnest Paul Arndt Minnie Ingram 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1825 Ramsey Street, Baltimore, MD 21223 Betty J. Arndt / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 1/22/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Victor P. 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc.

1501 Fast Fort Avenue, Baltimore, MD shock, or heart failure. List only one cause on each line.

Immediate Cause (Final) Immediate Cause (Final disease or condition resulting in death) MONIA **Physician** /Medical Due to (or as a consequence of) Examiner ERIOSCLERATIC CARDIOVAS CULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) Examine and Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Division or Vital Records, P.O. Box 68760, To the Hospital or Attend within 24 hours after death To the Funeral Director:

> Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

0 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2000

D0030355

BON SECOUR

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death dent's Name (First, Middle, Last) Month Year **Physician** Brown 7:40 PM JANUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death AGNES BALTIMORE HOSPITAL ST If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, 07-23 Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕶 F Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Baltmore 1 Mes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death v Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 | Yes 2 | If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo 2 Specify: 3 XWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working line. DO NOT use retired) 7 is marked other than "natu traumatic event, the Medical 16b. Kind of Business/Industry College (1-4or 5+) ndary (0-12) 10/11 17. Father's Name (First, Middle, Last, Mother's Name (First. Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Disposition 20a. Method o Important: If it any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the d shock, or heart to sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** >9 years ADRTIC STENOSIS, CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner >9 years CHRONIC FAILURE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RENAL Due to (or as a consequence of) Examine physician and s the burial-trans SEPSIS 4 DAYS Due to (or as a consequence of): or Vital Records, P.O. Box 68760. Physician/Medical LOWER GI BLEEDING I MONTH attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery CALLIE 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 dinknown Be Completed ROWN, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P21800 JANUARY 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PULICKEN, 900 S. CATON AVE, BALTIMORE, MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** 01 17 2008 Wayne L. Benway /Medical 19:15 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bel Air, Maryland Harford Upper Chesapeake Medical Center 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 1XM 2□F MaRyland Director 68 04/19/1939 216-36-4735 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 🏖 ☐ No Cecil Elkton Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code must be n 17 Joseph Gallaher Street 21921 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married ò 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heating & Air Condition Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Mildred Elberson Lester Benway

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17 Joseph Gallaher Street - Elkton, Maryland 21921 Susan A. Benway (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gds. 01/21/2008 Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown signed by t σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Ves 200 No Vital 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 100 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA Division 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO058475 PHTSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATWOOD ROAD PHILIP NIVATPI MIN, 602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23a per doc 9875 1-22-08 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** ELSIE PATRICIA BLAUVELT 15, 9:49 2008 A JAN. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARROLL WESTMINSTER CARROLL HOSPICE DOVE HOUSE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 ☑ F 216-38-3948 65 Yrs 2/17/1942 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MD CARROLL WESTMINSTER Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21158 USA 205 ST. MARK WAY, APT. 224 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any Injury or other traumatic every once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE SECRETARY BANK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CHARLES KELLEY WILSON ELSIE HENRIETTA HOUSMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21158 19a. Informant's Name/Relationship (Type. Print) ROBERT E. BLAUVELT-HUSBAND 205 ST. MARK WAY, APT.224, WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 01/19/08 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JOHN'S(Leister's)CEM. WESTMINSTER, MD 4 □ Donation 5 □ Other (Specify) ST. 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Olivopontocerebellar Atrophy Immediate Cause (Final In Furning Form R **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infline diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner physician and the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed, 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director 20 No Other: 4 Nursing Home 5 Residence 6 MOther (Specify)HOSPICE Hospital: 2 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural **Iniury** 5 Pending investigation 1 ☐ Yes 2 ☐ No ..s after dea. ¬I Director; A ¬I by # 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 01/16/2008 231660 21157 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS K. STUNER AVENUE Westmin ster mocyla CHLVW 291 ice MA 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** BEVERLY 2008 JOSEPH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F 89 Director 245-38-2781 October | 1918 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 X Yes 2 □ No notified Directo Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō pe 9510 50th Avenue 20740 items 23a United States "natural", or items 23a edical Examiner must permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Arborist Tree Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harley Beverly May Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Turgeon/Daughter 1814 McAuliffe Drive, Rockville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Boyds Presbyterian
Church Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State January 25, 1 N Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Boyds, Maryland 22 Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service License -M01173 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician Lostridium disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed physician and stran the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Hmknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending within 24 hours are:
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0003703 4600 CARROLL AV 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAKONA PARU, MD WAR SABYASACH

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 08 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Shirley W. Burch 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Hospita 5. Social Security Number / 6. Sex 17. Kosedale Center Himore If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min. 1 □ M 2 🔀 F Months Days Hours England 215 52 1736 70 July 22,1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2XNo Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1044 Foxwood Lane 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates 1 ☐ Never Married 2 Married 2 No Specify: White 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Wimbleton Sarah Mae Maudsley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emery Burch (Husband) 1044 Foxwood Lane Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory Inc. 1/18/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature 6 Funeral Service License Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 ohn W. Bur 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest sb ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💢 No Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred † ☑Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2. Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. Division or Vital Records, the Hospital or Attending To the Hosp... within 24 hours after de... To the Funeral Director

that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

with

death v

Burch

Maryland 2121

Baltimore,

Director

Funeral

2

Completed

Be

Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

4 Homicide

(Check only one)

Dr. Binh

29b. Signature and title of cer

31. Date filed (Month, Day, Year)

30. Name and address of person who completed c

Nauy

2 2 2008

29a. Certifier

r than "natural", or items 23a or 28a-f sh the Medical Examiner must be notified

Ith and Mental Hygiene.

27 Is marked other than '

Department of Health Important: If item 27 any injury or other tr

Physician /Medical

Examiner

and -tran

physician a s the burial-1

use

ρ

ed by the a

signed by

page 2 should

funeral director.

this

After

death.

after death Director: the

has certificate l

27

Pages 1 and 2 should be 1 nent of Health and Mental I

State Registrar

eath (Item 23a) (Type, Print)

Franklin

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Square Drive, Baltimore, MD 21237

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Paul C. Culver 14 2008 5:20 PM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Salisbury Wicomico Wicomico Nursing Home 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 28, 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday 5. Social Security Number **Funeral** Days Hours Min. Months 1 ☑ M 2 ☐ F 90 214-10-7072 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show at 1 ☐ Yes 2 ☐ No Examiner must be notified Director Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 1110 Healthway Drive items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🔀 No Completed by 3 X Widowed 4 Divorced unk permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Dopordant: If item 27 is marked other than "natuu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 craftsman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Strong Paul Culver ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28220 Nanticoke Road Salisbury, MD Lois Bradley/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street Signature of Funeral S. rv. Ronald S. Wade irector 21201 Baltimore, MD inn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASCVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760, the attending physician death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant et time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes ☐ No Month Day Year 5 Other (specify) signed by the all d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has this certificate 2J No 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XD NO 1 Inpatient 2 ER/Outpatient 3 DOA ျှ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation (Month, Day Year) Injury 1 □ Yes 2 □ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN

Yogesh

Vohra M.D

2 2 Easternshore, Dr Salisbury MD 21804

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

J.	
ó	
928	
37	
3	
×	
Box	
o.	
<u>α</u>	
Ś	
ō	
Ö	
9	
Œ	
a	
Ħ	
_	
ō	
.0	
is	
\leq	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 7:00 PM 12 2008 MAUNA <u>John Cameron</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PERRY Point VA MARYLAND HEALTH CARESYSTEM If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F unk Apr 9, 1928 Director 309-32-2124 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State unk 10b. County 10d Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at unk unk 1 □Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unk unk IISA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 M Yes 2 □ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🕅 No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation unk unk 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any injury or other traumatic event, the once. unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Point VAMC Perry Point, MD 21902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Euneral Service Licensee Ronald S. Wades 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Director 3a. P //1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, six ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Artery Disease **Physician** disease or condition resulting in death) CORONARY こうがくり りょうしょう /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed and Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Bipolar Disorder 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Nnpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sher A. HAShmi, M.D., VA MAY Land Health CARe System, Perry Point MD 21902 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 2 2008 STORE D Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			4 1,01	Certificate of Death		g. No.	01040					
	Physic	an	1. Decedent's Name (First, Middle, Last) Irene Anna Comeau		Date of Death	4 ^{Day} 2008	3. Time of Death					
	/Medi	cal	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Jaii i	4 ∠008 4c. County of Death	7:05a ^M					
	Examir	ier	Gilchrist Center	Towson		Baltimo						
	Funeral Director		5. Social Security Number 164-24-1709 6. Sex 1 □ M 2 ☑ F 7. Age (In yrs. last birth 77 Yr	tay) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. M	B. Date of Birth Month Day Iarch	O Dieth	place (State or Foreign ntry) PA					
	and and t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the country 10c. City,	r Location			10d. Inside City Limits					
	h the Maryland r 28a-f show notified at	tor	Md Baltimore E	ssex			1 □Yes 3√□No					
	ith the or 28a e noti	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Cou	ntry?					
	eath with	ral	418 Theresa Avenue	21221		USA						
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexicari, Puerto Ric 1 ☐ Yes 2 No Specify:	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,						
5-0	72 hc "natui dical	eted	15. Decedent's Education 16a. D (Specify only highest grade completed) (6	ecedent's Usual Occupation Give kind of work done during most of working fe. DO NOT use retired)	1 10	6b. Kind of Business/In	dustry					
121	e filed within al Hygiene. I other than " vent, the Me	Completed		itress		White Cof	fe Pot					
	filed I Hygi other ent, tl	Be Co	17. Father's Name (<i>First, Middle, Last</i>)	18. Mother's Name (F	1		100					
Maryland	2 should be and Mental is marked or aumatic eve	ToB	Anthony Urban	Anna '	Turkin	ak						
lan	2 sho and l is ma		l	lailing Address (Street and Number or Rural F								
	1 and 2 Health a			18 Theresa Avenue isposition (Name of Date								
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any Injury or othe once.		1 ⊠Burial 2 □ Cremation 3 □ Removal from State Parkw 4 □ Donation 5 □ Other (Specify)	crematory or other place) DOO Cemer tery 1/18	3/08 E	Oc. Location - City or To Baltimore	MD					
Bal	Depar Impor any in		21. Signature of Ineral Service Licens	22. Name and Address of Facility 300 Connelly Funera	a⊥ Home	e of Esse	x 21221					
	Physician		23a. Part 1. Enter the discase, of complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	enter the mode of dying, such as cardiac or remine right startic CANCC	respiratory arres	st,	Approximate Interval Between Onset and Death WELK S					
1	/Medical Examiner		Due to (or as a consequence of)	atic (Ano.	1		munter					
		er	Sequentially list conditions, in any, leading to immediate cause. Exhault lodelyting.									
	cuted	Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
68760,	rtificate be executed og physician and as the burial-transit	/ledical Ex	resulting in death) Last Due to (or as a consequence of) d.									
		/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy	, 100								
.O. Box	The law requires that the death cer ite has been signed by the attendin agge 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year					
Records, P	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba 1 □ Yes	cco use contribute to t	he cause of death? bably 4					
မင္ပ	law re as be	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available of					
<u>~</u>	siclan; The law certificate has t irector, page 2 s	Con			performe 1 Yes 2	ed2_ death?	2□No					
Vital	Physiclan: r this certific ral director, I	Be	25. Was case referred to medical examiner? Hospital: 4 The second of th	26. Place of Death (C	Check only one)							
ō	ing Phy After this uneral d	ition: To	1	e of 28c. Injury at 28c	e 5 Resident d. Describe how	ce 6 Other (Special injury occurred	nHospice					
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: v completely filled in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	street, factory, office 28f	f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,					
	the Hospi in 24 hour the Funer pletely fill	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, care in the basis of examination and/care and manner stated.	eath occurred at the time, date and place, and r investigation, in my opinion, death occurred	d due to the cau I at the time, dat	use(s) and manner as s te and place, and due t	itated. o the cause(s)					
	To t To t	Σ	29b. Signature and title of Certifier	29c. License number	290	I. Date signed (Month,	Day, Year)					
•	~		Milm Ing "	1023200	J.	Muitry	7,2005					
5	, ү			pe, Print). Charles St.	Beli	to and i	2,205					
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and the second								

DHMH 17 Rev 1/2001

JAN 2 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 25, perMD, g875, 1/22/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death James Ronald Coulter Physician January 17, 2008 10:04 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 25, 1939 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days Min XX M 2 F 68 213-36-8508 Marvland Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits show ed at "natural", or items 23a or 28a-f sh edical Examiner must be notified ? Harford Bel Air 1 ☐ Yes XX No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 402 Idlewild Road USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married white 21215-0036 1 □ Yes XX No Specify: þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Corbin Fuel Manager 12 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Mae Cora Samsel Harry Coulter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4730 Wiota Street-Los Angeles, California 90041 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 shand Department of Health and Important: If Item 27 is many injury or other traum Micheal Coulter-son Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition EVANS FUNERAL CHAPEL AND CREMATION—BEL AIR 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland Jan.19,2008 22. Name and Address of Facility
EVANS FUNERAL CHAPEL
AND CREMATION SERVICES 21. Signature of Funefal Service Licensee 3 Newport Drive Forest Hill,MD 21050 DIST 23a. Part1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hemorrhage ntrocraneal days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and Due to (or as a consequence of): P.O. Box 68760 physician Physician/Medical as attending properties as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy perform 1 Yes 2 certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No I Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or hours a To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065409 address of person who completed cause of death (Item 23a) (Type, Print) pper Chesapeake Dr. 32. Registrar's Signature State Registrar

Ronald

			1 - For State of Registrar		artment of Health and N rtificate of Death	lental Hygier	7000	01042
	Dhysisi		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		David Lloyd Cooper		1	01 1		4:00 PM M
}	Examin	er	4a. Fecility Name (If not institution, give street and num	nber)	4b. City, Town, or Location of Death		tc. County of Death	
			7454 Bradshaw Road 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Kingsville, Ma	aryland 8. Date of Birth	Baltimo	
В	Funeral		1XM 2□F	Vrc	Months Days Hours Min.	(Month, Day, Yea		nplace (State or Foreign untry)
	Director		212-09-2134 Usual Residence of Decedent	89 115.		11/14/191	о ма	ryland
	yland		10a, State 10b, County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mar.	ţ	MD Baltimore	Kingsvil	le			1 ☐ Yes 2√ No
	th the	Director	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Co	untry?
	15 wi		7454 Bradshaw Road		21087		U.S.A.	
	r dea	Funerai	Armed Fo	dent Ever in U.S. 13. rces?	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	or it	γFι		2□No WW II	1 ☐ Yes 2 ▼ No Specify:		Specify: Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23e or 28e-1 ehow ite Medicel Exercities trust be notified at	Completed by	3 Widowed 4 Divorced Year or Divorced 15. Decedent's Education	ates: Korean	dent's Usual Occupation	16h	Kind of Business/I	Industry
7	n 72	lete	(Specify only highest grade completed)	(Give	kind of work done during most of work DO NOT use retired)	ring	Training of Businessari	
72	with iene.	E	Elementary/Secondary (0-12) College (1		hnical Writer	M	artin Co.	
D	be filed within 72 hours after death with the Marylan Ital Hygiene. ed other then "neturel", or iteme 23s or 28s-f ehow event, the Maxical Exaction must be notified at	BeC	17. Father's Name (First, Middle, Last)			e (First, Middle, Maid		
Maryland	should be filed within and Mental Hygiene. marked other then metic event, the Mi	To B	William J. Cooper		Reba I	3. Flack		
ary	2 should and Men is marke		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street and Number or Rui		y or Town, State, Z	lip Code)
Σ	D = - =		_ Cornelia J. Cooper (w	ife) 7454	Bradshaw Road - I	Kingsville	, Marylar	d 21087
ore	of He of He fiten r oth		20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from		osition (Name of matory or other place)	Date 20c.	Location - City or	Town, State
<u>Ĕ</u>	Pag ment ent: i		4 □Donation 5 □ Other (Specify)	Highview	Memorial Gds. 01/	19/2008 Fa	llston, M	Maryland
Baltimore,	permit. Pages 1 an Department of Heat Important: if item 2 eny Injury or other once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility E. 1750 Belair Road			
п			23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause on e	aused the death. Do not en ach line.	iter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	E RESPIRA	TORY FAILURE			Onset and Death
	/Medical Examiner		resulting in death) Due to	(or as a consequence of):			- 65	
	Lxammer	_	Sequentially list conditions, if any, leading to immediate	VIC OBSTRU	ICTIVE PULMON	ARY DE	SEASE	
0	ed sit	ulne	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequence or,				
Ž	xecul and	Examiner	that initiated events c.	(or as a consequence of):				
8760,78	ate be executed hysicien and the burial-transit	cal						
9	ificate g phy as the	ed ed						
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	ivery Day Year
	wrequires that the deben signed by the should be detached		Part II. Other significant conditions contributing to de	eath but not resulting in the I	underlying cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	puires sign	d by				1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
<u>0</u>	w rec	Completed				24a. Was an	24b. Were at	itopsy findings available
æ	The lav	E S				autopsy performed	death?	completion of cause of
	iclan: 1 certificel ector, p	0	25. Was case referred to medical		26. Place of Dea	th (Check only one)	10 103	2010
≥	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ I	Inpatient 2 ER/Outpatie	Other	/	6 ☐Other (Spe	cify)
0	iding Phyeiclen: th. : After this certifice funeral director, p		27. Manner of Death 28a. Date	of Injury 28b. Time of th, Day Year) Injury	of 28c. Injury at Work?	28d. Describe how in	njury occurred	
Ö	Attending r death. ector: After by the fune	atic	2 Accident investigation	,,,	M 1 ☐ Yes 2 ☐ No			
Division of Vital	i or Attend efter death Director:	Certification;	3 Suicide 6 Could not be determined 28e. Place buildi	of Injury - At home, farm, sing, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St		ural Route Number,
	Hospita 24 hours Funerel stely filler	ledical C	(Check only 2 Medical Exeminer: On the b		th occurred at the time, date and place nvestigation, in my opinion, death occu			
}	To the Within To the comple	Me	29b. Signature and title of certifier	yankar m	29c. License number		Date signed (Mont	h, Day, Year)
	- 41		30. Name and address of person who completed caus	se of death (Item 23a) (Type	, Print)			2000
	121,		VIJAY M. ABHYAH	11.1.0	NORTH AVENUE	BELA	RR MD	2(014
	Sta	ate	5	legistrar's Signature	land a			
	Regist	rar	JAN 2 2 2008 J	added the for				
	D 41 L 47 D . 4 /0							

DHMH 17 Rev 1/2001

COOPER

DAUTS L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen M. Cornwell 17, 2008 A M January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 🛠 🔀 F 212-07-2573 Director 8-15-1920 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 📉 🔻 o Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 638 A Harborside Drive 21085 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: <u>Ş</u> ¥₩ Widowed 4 Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk London Fog 11th other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill trent of Health and Mental H tant: If item 27 is marked oth Jury or other traumatic even Be William Easton Doshie Sheehan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl L. Williams 534 Riviera Drive Unit C Daughter Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any Injury or once, 1/21/2008 Metro Crematory Catonsville, MD 21. Signatur f Funeral Service 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 23a. Part1. Enter the disease, or con shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only release on each line. Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Physician Cardio-vascular /Medical Due to (or as a consequence of) Examiner ertension Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examine The law requires that the death certificate be executed 1 perlipideni burial-tran o (or as a consequence physician s the burial Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ■ No Day Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? certificate has 1∐ Yes 25. Was case referred to medical 26. Płace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 □ DOA After this Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: 24 hours after death. filled in by within 24

State

Registrar

Medical

Inna Gendelsman

29b. Signature and title of certifier

29a. Certifier

(Check only

udeltwan

29c. License number

1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 18,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1205 York Road Lutherville, Maryland 21093

31. Date filed (Month, Day, Year) JAN 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 01044 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 02:30 AM 20 2008 Anneliese January /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital of Baltimore Battimore City Sinai 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Hours Director 219-40-8846 Usual Residence of Decedent July 08, 1930 Germany with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6723 Kincheloe Avenue 21207 United States Of America death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☐ No d be filed within 72 hours al antal Hygiene. ted other than "natural", or Specify: Specify: White 9 Widowed 4 □ Divorced

Divorced

Material Property States and A □ Divorced

Material Property States and A □ Divorced

Divorced

Material Property States and A □ Divorced

Material Property Sta Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Frietag Margareta Zapf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2
Department of Health a
Important: If Item 27 is
any Injury or other trau JoAnn Crue (Daughter) 6723 Kincheloe Avenue, Gwynn Oak, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 01/21/08 Catonsville, MD 21228 22. Name and Address of Facility Loring Byers Funeral Directors, Ind Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Certawascuar Accident 1 Weck /Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Due to (or as a consequence of). Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the attending physician and a be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Atrial Fibrillation 1⊠ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Renay Insufficiency 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 M Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Baltimore Jennifer Dunphy MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2008

Anneliese

された

08-00496 Dana Clark Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 01045

		1- For State Registrar		Certif	ficate of	Death			Re	g. No.				
Physicia		1. Decedent's Name (First, Middle,Last) Dana Clark 2. Date of Death Month Day Year January 17, 2008 3. Time of Death Month Day Year January 17, 2008												
Medical Examin	er	Dana			Clark			J.	anuary 17	, 2008		2125 hrs		
		4a. Facility Name (if not institution	on, give street and number	er)	41	b. City, Town, or	Location of	Death		4c. County o	f Death			
		University Hospital				Baltimore								
Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last	birthday)	If Under 1 Yea			Date of Birth	(MM/DD/YYYY)	 g. Birthpl Foreign 	ace (State or		
Director		212-94-9628	1 M 2 X F	33	Yrs.	Months Day	s Hours	Min.	11-19	-1974	Count	y) MD		
	ŀ	Usual Residence of Decedent												
any	Γ	10a. State 10b. County		10c. City, To	wn or Locatio	n						d. Inside City Limits		
nd Show	۱,	MD		Bal	timor	е					1	X Yes 2 No		
with the Maryland ns 23a or 28a-f show be notified at once.	該	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	at Country	?		
he M	틢	2726 55-14 3-				24224								
with with s 23; e not	Funeral Director	3726 Fait Av	12. Was Decede	nt Ever in U.S.	13. Was	21224 Decedent of His		n? (Specif		U.S.A. 14. Race	- Americar	Indian, Black,		
item item	림	1 Never Married 2 X M	Married Armed Force		If Ye	s, specify Cubar	, Mexican,	Puerto Rica	án, etc.)	White	, etc.			
fter d		3 Widowed 4 Div	1 Yes	2 X No	1	Yes 2 X No	specify:			Specify:W	hite	9		
ours a	함	15. Decedent's Education (Spe	ecify only highest grade of	ompleted) 16		s Usual Occupat				16b. Kind of Bus	siness/Indu	ustry		
72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 c	r 5+)	during mo	st of working life	. DO NOT u	ise retired)						
215-0036 be filed within 7 ntal Hygiene. 'ked other than ent, the Medica	립	12			Flo	oral De	esign	er		Dunda	1k 1	Florist		
5-0 ed w fygie other	ड़ऻ	17. Father's Name (First, Middle	e, Last)				18.Mother's	Name (Fir	st, Middle, M	laiden Surname)				
21 be fill ntal F	8	Gerald	Leonard	Hessle	er		Lisa	L		Grad	ce			
ID 21215-003 should be filed within and Mental Hygiene. T is marked other the marite event, the Med	- 1	19a. Informant's Name/Relations								ber, City or Towr				
MD and 2 shoulth and m 27 is aumatic		Gerald L. He	ssler -Fa	ther	3726	Fait A	venue	e Ba	ltimo	re, MD	212	24		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other transmatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition		20b. Pla	ce of Disposit	ion (Name of ce	metery,	Da	ate	20c. Location -	City or To	wn, State		
Pages ent of		1 X Burial 2 Cremation 4 Donation 5 Other S		Jiaic	•	t. of i	Jes.	1-22	-08	Baltim	ore.	MD		
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumant	ı	21. Sign tre of Funeral Service			1 00 N						<u>·</u>			
E P E		(fort	an		Jo	seph N	Conl	nnino klino	o Jr.	Funer	ат п	21 224		
Physician	T	29a. Part I. Enter the disease,	263 S. Conkling St. Balto MD 21224 a. Part I. Enter the disease, recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only operate on each line. Approximate Interventional Between Onset are											
/Medical	4	Immediate Cause (Final direase	TT 1 · · ·											
xaminer		or condition resulting in death)	Due to (or as a cor											
	ال	Sequentially list conditions,	b											
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	isequence of):										
	all	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	sequence of):										
uted nd ransit	Δĺ	Cronto recording in death) Last	d.											
ffcate be executed gphysician and the burial - transit	n/Medical	X UNPENDED	AMENDED #23a,27	20. 6 -	- ML5 - O.	78: 0/1/6	70 mm							
8760, ifficate be ug physic is the bur	좕	IF FEMALE:	#23a,2/ 23c. If yes, outo	,∠OaTI, D ome of pregnar	enue, go	700, Z/1/C	<i>J</i> O 11			23d. Date of	delivery			
	틸	23b. Was decedent pregnant in the past 12 months?	he 1 Live birth		2 Feta	al death 3	Ectopic	pregnancy		Month	•	Year		
Box 6876 e death certificate the attending phy ed for use as the b	Physicial	1 Yes 2 No 9 V Un	de-sour l'	at time of death	5 Oth	er (Specify)				ķ.		d		
he de	ٳۼۣ		9OIIKIIOWII						00 - D'11		1 1 1 1 1 1 1			
P.O. es that the gened by be detach		Part II. Other significant condit	tions contributing to de	ath but not resu	ilting in the ur	iderlying cause (given in Par	t 1.				e cause of death?		
S, F uires n sign	Completed by							!!!						
ords, w requir	흥								24a. Was a autops	sy p	rior to con	sy findings available apletion of cause of		
Rec The la	팅								perfor		eath? Yes	2 No		
Vital Rec	Be -	25. Was case referred to medica				26.Place	e of Death (Check only	one)					
of Vital Records, ag Physician: The law require this certificate has been similared director, page 2 should be	0	examiner?	Hospital: 1 Inpa	tient 2 🗸 EF	R/Outpatient	3 DOA	Other ₄	Nursing H	ome 5 1	Residence 6	Other:			
of ng Pl	5	27. Manner of Death	28a. Date of Ir (Month, Day	njury 28	Bb. Time of In	jury 28c. Inju	ry at Work?			ow injury occurre		·		
Sion vttendii death. ctor: / y the fi	흷		ding 1/16/2000		:00 am	1 ,	Yes 2 X		ollision		auto-1	ixed object		
Division tall or Attending as after death. al Director: A led in by the fu	<u>≅</u>		Sugation			, factory, office b	ouilding, etc	. 28f	Location (S	treet and Number		Route Number, City		
Division of vospital or Attending Phours after death. In meral Director. After the y filled in by the funeral	Certification:	Odioido		9th St. E	Bridge w	est of Sis	sson St	. 2	or Town, St 9th St.	Bridge w	Baltin est of	ore. MD Sisson St.		
8 = = >		29a. Certifier 1 Certifying P	hysician: To the best of	my knowledge,	death occurre	ed at the time, da	ate and place	ce, and due	to the cause	e(s) and manner	as stated.			
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Exa	aminer: On the basis of ex and manner state	amination and/	or investigation	on, in my opinior	i, death occ	urred at the	e time, date a	and place, and d	ue to the c	ause(s)		
H S H S	Ĭ	29b. Signature and title of certific		1.1		29c. Licens	e number			29d. Date signe	ed (Month	, Day, Year)		
Philip		Millian	Big in (1)	M		O.C.	M.E.			January 18	, 2008			
,	+	30. Name and address of person	who completed cause of	death (Item 23	a)									
2 7		Melissa Brassell, MD	Assistant Medic	al Examiner	111 Pe	enn Street, E	Baltimore	, MD 21	201					
Sta	te	31. Date filed (Month, Day, Year)	32. Régist	rar's Signature	Ans	100								
Registra	ar	JAN 2	2 2008	المحاضل المستمانية	Color Parket									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William J. Christopher 19, 12:10 AM 2008 January */Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mariner Health Center Overlea Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | DeC 1 1, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 80 276 22 6335 Yrs. Director Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Essex 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 931 Garden Dr. Apt. 21221 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Korean Year or Dates: War 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 1 No ò 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Manufacturer Production Worker other permit. Pages 1 and 2 should be fit.
Department of Health and Mental Hy
Important: If Item 27 is marked other
any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Christopher Mary DeJohn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 294 Dennison Dr. Southbridge, Massachusetts 01550 Joanne Battista (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith Cemetery 1/21/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 0 1407 Old Eastern Avenue Essex, Maryland 21221 Fax 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCER KROSTATE **Physician** /Medical Due to (or as a consequence of): Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examir death certificate be executed and Due to (or as a consequence of): as the burial-Box 68760, physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2□ No 3 Probably 4 Denknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy The 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 21 No Hospital: 1 ☐ Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? Division To the Hospital or Attending 1 Natural Within 24 hours after usus.

To the Funeral Director: After 5 Pending investigation 1 🗌 Yes 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD and address of person who completed cause of death (Item 23a) (Type, Print) Waldham Words load. 8813 82. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 12:00PM aus on 2008 17 4a Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Manor Nursing tome Date of Birth (Month, Day, Year) (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Davs Hours Months 1□M 2**M**F 0 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 17 Ia marked other than "natural", or Items 23s or 28a-f abov traumatic event, the Medical Exertitual be routified at Saltimore 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numb Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 1 If Yes, Give Year or Dates: 72 hours after 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: **D**lack þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
tie. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within 3 Health and Mental Hygiene. em 27 la marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) omestic omes 18. Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last Be Dward olemar City or Town, State, Zip Code) 19b. Mailing A ess (Street and Number Catonsville, and 21228 permit. Pages 1 and 2 Department of Health a Important: If item 27 la any injury or other trav 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 21. Sign ture of Funer S rvice Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear tailure. List only one cause on each line. Approximate Interval Between Onset and Death one cause on each line. Immediate Cause (Final disease or condition resulting in death) Accident eresto umenta Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the burial-transit Due to (or as a consequence of): Box 68760,7 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Oprew lan Decare enocclessed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed seventa 1 ☐ Yes 29100 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Gursing Home 1 Yes 2 Ho 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? e Hospital or Attending Pl 24 hours after death. e Funeral Director: After ti Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 2 01-18-2008 DISLEY wow +508 Glen During Tid 2,061 parson who completed cause of death (Item 23a) (Type, Print) Ritelin 7310

State

Registrar

32. Registrar's Signature

The State of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Physician 6:38 PM SERH UNBAR ANURRY 15,2008 /Medical (Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11more 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 60 Months Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show Examiner must be notified at Director 1 Nes 2 No imore 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a or 21205 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant I flem 27 Is marked other than "natural", or Ite 1 Never Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced ack Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) mousine 17. Father's Name (First, Middle, Last) Be ea bay ဂ္ e Informant's Name/Relationship (Type 19b. Mailing Address (Street and Numbe City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Si maure of Funeral Service 23a. Part1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ESPIRATORY burs /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Luc to for as a consequence of requires that the death certificate be executed APLASTIC Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe (es 2) certificate Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 □ DOA 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 🗌 Yes 2 □ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 21108 D0035466 BALTIMOR death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of MD PUAN MID 32 Registrar's Signature 31. Date filed (Month, Day) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2_Date of Death 3. Time of Death Day **Physician** Jean W. DeVan 18 2008 INUARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Deat Examiner Baltimore - Washington Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthda 8. Date of Birth Month Day, May 10, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 👿 F 72 Pennsylvania Director 219-40-3274 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant; If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Director MD Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1833 Montevideo Road 20794 U.S.A. by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【No Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Blind Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. Wells Nora A. Broyles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Devan, Laura Pierce/Daughter 1833 Montevideo Rd. Jessup, Md 20794 20b. Place of Disposition (Name of cemetery, grematory prother place)
Meadowridge Memorial 1-22-2008
Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus Md 21227 21. Signature of Funeral Service Licenses repec 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 312 (2M T) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examine burial-trans certificate be execut and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 ☐ Unknowr signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has was and autopsy performed?/ Yes 2 1 No page 2 this certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **№**0 2 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: mpletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) after (4 ☐ Homicide hours 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 2 who completed cause of death (Item 23a) (Type, Print) address of perso 501 20161 Hos Artal 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				State of Maryland /	Depa		of He	alth a		ental Hyg	iene g. No. 20	8 (01050
	Physici		1. Decedent's Name (First, Middle, Last)	DRUMMOD	D					2. Date of Dear Month	Day	Year OB	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give so Howard County Gene	reet and number) ral Hospital			lumk				4c. County o	f Death	
	Funeral Director		5. Social Security Number 213-46-6728 Usual Residence of Decedent	7. Age (In yrs. last I	Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Birth (Month, Day) Feb. 8,	1945 S	South	lace (State or Foreign try) Carolina
	se Maryland	Director	10a. State 10b. County Maryland Howard	10c. City, To	olumi	bia					0g. Citizen of W		0d. Inside City Limits 1 ☐ Yes 2 🖾No
	3a or 2	I Dire	10e. Street and Number 5491 Blue Coat Lar	ne		10f. Zip C	1045	5				S.A.	uyr
980	d within 72 hours after deeth with the Maryland jene. Ir than "natural", or iteme 23a or 28a-f ehow Ir Madical Examinar rust be notified at the Madical Examinar rust be notified at	by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1		Was Decede f Yes, specif 1 Yes 2			gin? (Spec , Puerto F	cify Yes or No- lican, etc.)		, White,	an Indian, etc. ack
Maryland 21215-0036	within 72 ho ene. than "natur he Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual kind of work DO NOT use emaker	done du retired)	ion iring most	of workin	g	16b. Kind of Bus		dustry
yland 2	be file tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last) Eloyd Ross					Az	alea	n Foste			
	s 1 end 2 should if Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type Percy E. Drummond	(Husband)	5491	Blue	Coat		e C	olumbia	, City or Town, S , MD 210 20c. Location - 0)45	
Baltimore,	Pages ment of ent: If It		20a. Method of Disposition 1 XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligense	emoval from State Mary Ceme	fand tery	Natio	naTe	of Facility	<u>-19-</u>	2008	Laurel,	Mar	yland
Ba	Departi Import any inj		23a. Part1. Enter the disease, or complic	ulman		Witzke 5555 I	Fur Win	era Knol	ls R		lumbia,	MD :	21045
68760,	Physician /Medical Examiner physician and p	dical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consequence HV PERK	4LE :0 of):	2 No Hi A				erol			Interval Between Onset and Death
P.O. Box 6	that the death certificete ed by the ettending phy: detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death		Ectopic pre					23d. Date Mon		ery Day Year
	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions con	inbuting to death but not resulting	g in the u	nderlying car	use giver	n in Part I.					he cause of death? pably 4 Unknown
Division of Vital Records,		Completed by	Hyperten	sion'						24a. Was a autop perfor	med? pi		ppsy findings available impletion of cause of 2 Ano
Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☑ ER/	Outpatier		Other	~		(Check only or ne 5 ☐ Resid	ne) ence 6 □Othe	r (Specii	(v)
ion of	ling After fune		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		o. Time o Injury		c. Injury Work		2		ow injury occurre		
Divis	\$ 00 E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)						City or Tow	n, State)		al Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	ledical	(Check only 2 Medical Examin	icien: To the best of my knowled er: On the basis of examination and manner stated.	and/or in	vestigation, i	in my op	inion, deal	d place, a	ed at the time, o	date and place, a	nd due t	o the cause(s)
	Voit To Corr	Σ	29b. Signature and the state of	~ (i)		29c.	License)		4-	117/	29d. Date signed	12	008
	18		30. Name and address of person who con	mpleted cause of death (Item 23:	a) (Type,	Print) Ced	an	lan	e. (-olun	bia,	MD	21044
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 2 200	32. Registrar's Signature	44	136 Bland							

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 22

2008

32. Reistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of Maryland	•		Mental Hygi	ene	01052
		State Registrar		Centri	cate of Death		g. Nb. UUU	01032
Physici	an	Decedent's Name (First, Middle, Las				2. Date of Death Month	Dav Year	3. Time of Death
/Medic		Leneus_	ERVIN	1 45	Oh. T	prung	18 2008 4c. County of Death	
Examin	er	4a. Fecility Name (If not institution, give		~ ,	City, Town, or Location of Deat	11005	4c. County of Death	A
		5. Social Security Number 6. Se	URS 17. Age (In yrs. last		Inder 1 Year If Under 24 Hrs	8. Date of Birth	9 Birth	place (State or Foreign
Funeral Director			M 2□F		nths Days Hours Min.		Year) Soul	
		Usuel Residence of Decedent				July 12	.1719 000	77.67//04-17
yland		10a. State 10b. County	10c. City, 1	own or Location	B	0	,	10d. Inside City Limits
a-f.	cto	MARILAND N	IA		DALTIMOR	E (17	7/	1 A Yes 2 No
ith the	Directo	10e, Street and Number	1 4 - 1 = -	10	f. Zip Code	<i>A</i> 10	of Citizen of What Cou	ntry?
death with the Maryland ims 23a or 28a-f show ir must be notified at		11 GORMA	N AVENUE		2122	3	USA	•
or deg	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was I	Decedent of Hispanic Origin? (5 , specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
(1215-60036 within 72 hours after death with the Marylan ene. than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	101	es 28 No Specify:		Specify: 13	DOV
15-UU36	edt	15. Decedent's Ed		16a. Decedent's	Usual Occupation		6b. Kind of Business/Ir	ndustry
27275-0 1 within 72 ho jiene. rithan "natur tra Medical	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	(Give kind life. DO N	of work done during most of wo OT use retired)	rking	0	10
d with a second	E	Elementary/Secondary (0-12) 4 +++GRADE	College (1-401-54)	ONST	RUCTION WO	RKER	AJ PAR	ROTT CO.
and 2 d be filed ental Hygid ced other c event, L	ВеС	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, M	faiden Sumame)	1 = 1
	10	NATHANIEL	. <u></u>	RVIN	LOAR	BARA	00,	HNSON
C		19a. Informant's Name/Relationship (7		19b. Mailing Ad	dress (Street and Number or R	ural Route Number,	City or Town, State, Zi	p Code)
C = 44 P			(GRAND-DAUGHTER)	I/N,	GORMANA	Date DAL	THORE, MY	021223
OT C		20a. Method of Ďisposition / 1⊠Burial 2 ☐ Cremation 3 ☐	cem	e of Disposition etery, cremator	y or other place)	Oake .	20c. Location - City or T	Own, State
Fart:		* 4 □ Donation 5 □ Other (Specify	0/1/	RISON,	FOREST 101-	29-08 6	WINGS M	LLS MD.
Baltım, permit. Pag Department Important: I		21. Signature of Euneral Service Licen	6 M. W. Main	22. Na	ne and Address of Facility	SEDWIN-	JK. PUNEK	ALMOME
		23a. Part1. Enter the disease, or comp	plications that caused the death.	Do not enter the			ALIO, M.D	Approximate
		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		0 0	7.0	ofin	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consequer		yocorbial	arjer	icury	
Examiner			Arleris	250	ue Corde	ocesce	Da Dixes	e'
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer		at 0 '			
cuted	Examiner	Cause (Disease or injury that initiated events	· Dowel	06	struckon	>		
8760, and ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):				
	dical	•	d				-	
K 6	Mec	IF FEMALE:	23c. If yes, outcome of pregnance				00 (0-1) - (4-1)	
. BOX 68 death certifica e attending pt nd for use as t	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal de	eath 3 Ecto	pic pregnancy er (specify)		23d. Date of deli- Month	Day Year
	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of deat 9□ Unknown	11 5 0 0 0	el (specily)			
Hecords, P.O. The law requires that the date has been signed by the bage 2 should be detached	Completed by Physician/Me	Part II, Other significant conditions c	ontributing to death but not resulti	ng in the undert	ying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
dS uires ng sign d ble	d b	Imperteusi	\sim			1 🗀 Ye	s 2 No 3 Pro	babiy 4 Donknown
w red	lete	Coversal	Valculy	Acci	lent	24a. Was a		opsy findings available
if VITAL RECORDS, nysician: The law requires t nis certificate has been signe director, page 2 should be	mo	throw Cut	clarema.			autops perform 1 Tes 2	ned? _ death?	ompletion of cause of 2□ No
	Be C	25. Was case referred to medical			26. Place of De	ath (Check only on		
Of VI	ToB	examinar 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Impatient 2 □ EF	VOutpatient 3	□ DOA Other: 4 □ Nursing I	Home 5 ☐ Reside	nce 6 Other (Spec	ify)
On O		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	28c. Injury at Work?	28d. Describe ho	w injury occurred	
SIOI endir eath. or: At	atlc	2 Accident investigation		N	//			
DIVISION OF all or Attending Phy after death. I Director: Atter this d in by the funeral d	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, farm, street, f	actory, office	28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
Dital of urs all peral Dilled i		00 0 viti - D	isiah. Tashahashashashashashasha	des desth see	was diet the time date and along	o and due to the or	weeks and manner as	stated
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exan	ysicien: To the best of my knowle niner: On the basis of examination and manner stated.	n and/or investig	pation, in my opinion, death occ	urred at the time, do	ate and place, and due	to the cause(s)
o the o the omple	Me	29b. Signature and title of certifier	4 0		29c. License number	2	9d. Date signed (Month	, Day, Year)
->-0		De R	Vachs 1	m_	D00347	30 1	Enculsion 1	8, 2008
041		30. Name and address of person who	completed cause of death (Item 2	3a) (Type, Print)	J	1	8, 2008
7,		NONUVAN PARKE	s, Bon Secour	s Hosp	ital, 2000 W	Baltin	iere Street	IT built no
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	0	, B		,	21
Registr		JAN 4 Z Z	008 Jugus 1	40234	E. M.			
DHMH 17 Rev 1/2	001			19				

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Albert Lee 10. 2008 РМ Ensor Jan. 3:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dove House Hospice Carrol1 Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 12, 1 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1K M 2 □ F Director 213-38-8583 65 Sept. MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 'natural", or items 23a or 28a-f sh dical Examiner must be notified 1 ☐ Yes 2 No Director MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15109 Eastview Drive 21155 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Assembly Foreman Powermatic permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If item 27 Is marked other any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerald Merryman Ensor Virginia Laura Forwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Crocker Ensor 15109 Eastview Drive, Upperco, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State All Saints Cemetery 1-14-08 4 ☐ Donation 5 ☐ Other (Specify) Reisterstown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility 11824 Reisterstown Rd. hanM 10 ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. pproximate nterval Between oset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of): Examiner Sequentially list conditions, if a sequentially list conditions, if a sequential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the asn. IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No for Month Year Day 5 Other (specify) P.0. ed by the a 9 Unknown signed b Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to We cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page perform certificate Physician: 25. Was case referred ** medical Be 26. Place of Death Check only one) examiner Other: 4 Nursing Home 5 Residence 1 Yes Certification: To 2 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) After this funeral r of Death 28a. Date of Injury 27. Man. 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) 1 Naturai 2 Accident 5 Pending investigation death. 1 Yes 2 No after death the 1 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Hospital crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of c 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) ar 555 South

State Registrar

31. Date filed (Month,

Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #30 Per DWR 0875 1/22/08 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 6:15 P M January Earl Ambrose Eldreth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth March 30, 1928 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **3** M 2 □ F Months Days Hours Min. 217-24-6900 79 NC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Frederick Frederick Md Director 1 ☐ Yes 2 ☐ XIo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1001 Riverwalk Place 21701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Umerley Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dolphus W. Eldreth Essie E. Gilley ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11014 Horseshoe Drive Frederick MD 21701 Donna Bradford /daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Holly Hill Cemetery 1/24/08 IX Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto.MD 21. Sign ture of Juneral Service Luensee Connelly Funeral Home of Essex 21221 ms that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part1. Enter the disease, or cord shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final MYELODY SPLASTIC **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No certificate has b irector, page 2 sl 24a. Was an 2**X** No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 2 ER/Outpatient 3 DOA 1 X Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 028808 MD 0112012,008

Registrar DHMH 17 Rev 1/2001 Frederick.MD.

32 Registrar's Signature

STAR!

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 Seventh St.

Florin Rusu

JAN 2 2 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

10

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Terrence A. E1kes 18 January 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Min 054-28-6321 M 2□ F Director 73 April 28, 1934 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at NY Westchester Rye 1 Tores 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 Trails End 10580 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. White Specify: 3 XWidowed 4 ☐ Divorced Completed It of Health and Mental Hygiene.
If item 27 Is marked other than "nature or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Important: if item 27 is marked other the any injury or other traumatic event; the once. Principal Partner Finance 12 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sydney E1kes Beatrice Sachnin 19a. Informant's Name/Relationship (Type. Print)
Steven Elkes / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 Hirst Road, Briarcliff Manor, NY 10510 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 1/21/2008 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral HomeInc. 21. Signature of Funeral Service Licensee h. Moushall revet a 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONGUESC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 W No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No Vital 1 Yes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Ye 2 ER/Outpatient 3 □ DOA ō 27. Manyer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

30

80

0

State Registrar 8600 Old GeorgetennRd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CARMODY, BRENDON

31. Date filed (Month, Day, Year)

2008

DHMH 17 Rev 1/2001

State

Registrar

Year)

2008

JAN 2 2

31. Date filed (Month, Day,

32. Aegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Maryla		irtment of F tificate of		ı Mental H	ygien Reg. Ni	21111	0105
Physici		1. Decedent's Name (First, Middle, Las	(KATHLEEN	ANN FI	ROCK		2. Date of D Month	Dath Da	y Year	3. Time of Deat 10:12 F
/Medic Examir	_	4a. Facility Name (If not institution, give CARROLL HOSPIT			4b. City, Town, o	r Location of De	ath	40	CARROL	th
uneral irector		213-40-2270	7. Age (In yr.	s. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		ay, Year		thplace (State or For ountry) RYLAND
-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD CARROL		City, Town or Lo				-		10d. Inside City Lin 1 ☐ Yes 2 🔀
a or 28a be noti	Director	10e. Street and Number	77.T.DV. DD		10f. Zip Code	F.0			itizen of What C	ountry?
e. en "natural", or items 23a or 28a-f show Medical Examiner must be notified at	by Funerai	125 BACHMANS V 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:		Vas Decedent of F Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)		SA 14. Race - Am Black, Whi Specify: WH	te, etc.
r then "natura the Medical E	Completed I	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation	(Give	lent's Usual Occup kind of work done DO NOT use retire ISTRATI	during most of v d)	-	COU	Kind of Business INTY ERNMEN	/Industry
d other	To Be Co	12 17. Father's Name (First, Middle, Last)	LAYTON THEO	DORE K	OONTZ	18. Mother's N	lame <i>(First, Midde</i> CTTA LEI	NORE	n Sumame) SCHNA	UBLE
t neally and wer them 27 is marke other traumatic		19a. Informant's Name/Relationship (7) WILLIAM FROCK	уре, Print) – HUSBAND		g Address <i>(Str</i> eet BACHMAN					^{Zip Code)} 2115 'ER, MD
		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specify	Removal from State		sition (Name of natory or other pla		Date 4 / 08		ocation - City of	Town, State
Important: If eny injury o		21. Signatury of Fineral Service Licen		22	. Name and Addre	ss of Facilit	ETCHER	FUN	ERAL H	OME, P.2 D 21157
/sician ledical aminer	iner	shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a conse	equence of):	ARTER	4 01:	55/5E	-		Interval Between Onset and Deat
physicien and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	equence of):						
ed by the attending pl detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ ₩6 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	Ectopic pregnanc	y			23d. Date of de Month	olivery Day Year
5 9	by	Part II. Other significant conditions of	ontributing to death but not re	_	nderlying cause gn	ven in Part I.		tobacco		o the cause of death
ate has been si page 2 should	Completed	HYPERTER	15100					opsy formed?	prior to death?	utopsy findings avai completion of cause s 2 \(\subseteq \text{No} \)
is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:		. 0**		Death (Check only	one)		
After this funeral di	ation: To	1 Yes 2 Ho 27 Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Inju	y at rk? Yes 2 No	28d. Describe			əcify)
leral Director: filled in by the	27. Manner of Death 1									lural Route Number,
Fur	edicai		/sician: To the best of my ki iner: On the basis of examinand manner stated.							
To the complet	Me	29b. Signature and title of certifier	21		29c. Licens	re number	-		ate signed (Mon	th, Day, Year)
	1	30. Name and address of person who	mann	_						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	odenán III		1 - For State Registrar	State of	Marylar		artmen rtificat			and M	ental Hy	giene	4 U U (8 0	1059)
	Physic	ian	1. Decedent's Name (First, Middle, La.	st)							2. Date of De	ath Da	y Ye		ime of Death	
	/Medi		Robert Raymond								Janua	ry 1	8, 200	08 14	407 ^M	1
).	Exami	ner	4a. Facility Name (If not institution, green		oer)				Location o	f Death			. County of D			
		, e ²⁰⁰ .	10109 Burton G16 5. Social Security Number 6. S		Ago (In use	last birthday)		kvil 1 Year	le	24 Hrs	0. Data of Bio	_	Montgo			_
1	Funeral Director		035-16-6882 Usual Residence of Decedent	ŽM 2□F	89	14	Months		Hours	Min.	8. Date of Bir (Month, Da May 18	y, Year)		Country) EW Jer	State or Foreigi sey	7
	/land		10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Ins	ide City Limits	,
	hours after death with the Maryland tural; or Iteme 23a or 28a-f show at Exeminal the notified at	Director	Maryland Montgom	ery	Roc	kville]Yes 2∐ No	1
	with t	ā	10e. Street and Number	D .			10f. Zip						tizen of What	t Country?		
	72 hours after death with "natural", or Iteme 23a o	Funeral	10109 Burton Glen 11. Marital Status		ent Ever in I	J.S. 13.)850	coanio Orio	nin2 /Sno	oity Vac or No	U.S		American Indi	20	
10	fler d	Fun	1 Never Married 2 Married	12. Was Decede Armed Force 1X XYes 2	es? □No 10	4.2	If Yes, spec	offy Cuba	n, Mexican	, Puerto l	cify Yes or No Rican, etc.)	,		Vhite, etc.	idii,	
036	urs aff		3 ☐ Widowed 4 ☐ Divorced	1XXYes 2 If Yes, Give Year or Date	s: 19		1 Tes	% №	Specify:				Specify: V	√hite		
0	72 hours "natural",	Completed by	15. Decedent's Ed		1,7	16a. Dece	dent's Usua	al Occupa	ition			16b. K	ind of Busine	ess/industry		
21		ple	(Specify only highest gra	College (1-4	or 5+)	life.	DO NOT u	se retired	luring most)	of workir	ng					
2	od wi	Son		4	,	Aero	nauti	ca1	Engin	eer		Nav	y_Depa	rtment	t.	
pu	d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	(First, Middle					
V a	Ment Ment arke	ျှ	Raymond S. Francis	5		-			Marg	aret	Carro	11				
Maryland 21215-0036	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other then "tor other traumatic event, Ita Muc		19a. Informant's Name/Relationship (Patrick Francis -								e, Rocl					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is eny injury or other tra QDCE.		20a. Method of Disposition		20b. I	Place of Dispo	estion (Nar	ne of		D	ate	_		or Town, Sta		
a G	Page: ent o nt: if y or		1 Burial 2 Tremation 3 4 Donation 5 Other (Specific	Removal from Sta	ate Mo	cemetery, crei ney & ematio	natory or o King P	ither place	9) J	anua 3, 2	•	Ch -		57.4 and		
	nit. F artmoortar injur		21. Signature of Funeral Service Licen		CI				s ol Facility		008			, Vir		-
Ba	Depa Impo eny ir		Methat III		100968					•	1 Home			-		
100			23a. Part1. Enler the disease, or com	olications that cau	sed the dear							-	emia,	Appro	ximate	-
	Physician		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on eac	n line.	11 Can								Interva Onset	al Between and Death	
	/Medical Examiner		resulting in death)		as a consec											
	4:	<u>_</u>	Sequentially liet conditions,	0		tery D	1seas	е								
	Bla =	Examiner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Hypert	as a consec											
_	cate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	C	as a consec											
8760,	be e. icien buria	<u>m</u>		500 10 (01	43 4 0011350	quorice or).										
387	phys phys s the	dlcal		d												-
9 x	eath certific attending pl	Physician/Me	IF FEMALE:	23c. If yes, outcome	me of pregn	ancy			CHIEF TO THE							
Box	atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	al death 3	Ectopic pr						23d. Date of Month	delivery Day	Year	
Ö	that the de led by the a detached	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow		eath 5	Other (sp	есту)						,		
P.0	that t		Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the w	nderlying c	alica diva	n in Part I		23e Did t	obacco i	ise contribut	e to the caus	e of death?	_
Vital Records,	96 Ded	d by		3		,		asso g	ar iir r care ii						4 ∐Unknown	ı
000	w requir	Completed									24a. Was		24h Mara	autonou line	dia a a su sula la la la	-
Re	The lav	Ë									autor		prior death	to completion	dings available n of cause of	,
ā	ician: Th certificate rector, pag		25. Was soon referred to medical								1 Yes	2 🖾 No	101		0	
₹	Physician: this certificant all director, i	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only o					7
of	Phys r this ral dir	- T	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpa		ER/Outpatien			4 1401		le 5 ØResid 8d. Describe I			Specify)		
O	ding th. After funer	tion	1 Natural 5 ☐ Pending	28a. Date of ! (Month,	Day Year)	Injury	M	Bc. Injury Work	?" ′es 2 ⊡ N		od. Describe i	ion injui	y occurred			
Division	death death ctor; y the	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of	Injury - At h	ome larm str					81. Location (Street an	d Number or	Rural Route	Alumber	
Ξ	after Dire	ert	4 Homicide determined	building,	etc. (Specif	(y)	eet, lactory	, once		_	City or To	vn, State)	nurai noute	rvum <i>ber</i> ,	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Medical C	29a. Certifier (Check only 2 Medical Exam	Iner: On the basis	s of examina	owledge, death	occurred a	at the tim	e, date and inion, death	l place, a	nd due to the d at the time,	cause(s)	and manner	r as stated.	use(s)	
	ithin ithe	Med	one) 29b. Signature and title of certifier	and manner	stated.			. License						ρητή, Dey, Ye		
	F 3 F 3		Q	1 2.1	1,00.					1,-		25G. Dai) i	Same Doy, Ye	3.	
			granul	wwy	WILH	V		100	197	82		_	1211	200	8	
0	10+1		30. Name and address of person who of Frauke Westphal,	M.D., 12	ol death (Item 01 Sex	n 23a) (Type, 7en Loc	Print) :ks Ro	oad,	#202,	Roc	kville	, Ma	ryland	1 2085	4	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regi	strar's Signa		and the s						-			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month
January 17 cu **Physician** CO25 MM Della Joyce Flint S008 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2√2 F 71 Director Aug. 9, 1936 Maryland 217-36-3953 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene, Institution items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. once. 1 ☐ Yes 2X No Director Harford Maryland Joppa 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21085 USA 331 Elsworth Place Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by Maryland 21215-003 White 3₺ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant 10 Waitress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glen Walter Bauquess Rosie (unk) Kilby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 331 Elsworth Place, Joppa, Walter D. Pack / Son MD 21085 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 1-21-08 | T 22. Name and Address of Facility McComas Funeral Home, P.A. 1-21-08 Towson, Maryland onature of Funeral Service Licensee 23a. Part1. Enter the fisease, or complications that caused the shock, or heart failule. List only one cause of each line. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** achycardia minutes /Medical nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown ryper ensur 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page Vital Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3DOA 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. January 17, 2008 29c. License number 29b. Signature and title of certifier Jun, mil. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harford Road, Suite 105, Fallston MID M.D. 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

A VAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For amend #18	State of M Per FH	arviano G876	d/Depa 2/04/6	artment of H	lealth a	and Me	ntal Hygi	ene (801	01061
	Physicial		Decedent's Name (First, Middle, Last						2	. Date of Death	1	Year	3. Time of Death
	Physici /Medic		MAURICE			F.P	RB			ANUARY	15	2008	2:45 P M
	Examin	er	4a. Facility Name (If not institution, give MANOR CARE RUXTON	street and number)			4b. City, Town, o	r Location of TOWS				nty of Death	
	Funeral		5. Social Security Number 6. Se		ge (In yrs. la	ast birthday)	If Under 1 Year	If Under	24 Hrs. 8	. Date of Birth		9. Birth	place (State or Foreign
	Director		215-14-4622	M 2□F	87	Yrs.	Months Days	Hours	Min.	14742/1	920	Col	MD MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
	Marylan f show	tor	MD BALTIN	10RE			IMORE						1 Tes 2 No
	th the	Director	10e. Street and Number		1		10f. Zip Code			10	g. Citizen	of What Cou	untry?
	within 72 hours after death with the Maryland ene. than "neturel", or Items 23s or 28e-f show ha Medical Examiner must be notified at		3404 STEVENSWOOD					1244				USA	-
	ter de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X	Ever in U.S No		Was Decedent of F f Yes, specify Cub	lispanic Orig an, Mexican	gin? (Specif 1, Puerto Ric	ty Yes or No- can, etc.)		Race - Amer Black, White	, etc.
21215-0036	ours a	þ	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:			1□Yes 21No	Specify:			Spe	cify: WH	ITE
5-0	72 hours "neturel",	etec	15. Decedent's Edu (Specify only highest grad			(Give	dent's Usual Occup kind of work done	during most	t of working	1	6b. Kind o	f Business/I	ndustry
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire RVISOR (C		AN)	м	ARYLA	ND ST	ATE POLICE
1d 2	be filed within 72 ho ital Hygiene. d other than "netu event, the Medical	Be Co	17. Father's Name (First, Middle, Last)							First, Middle, N	faiden Sun	name)	
Maryland		ToB	NATHAN			FARB			MARY	Rosto			
	d 2 s th an 17 ls trau		19a. Informant's Name/Relationship (T) CAROLE BREDENBURG		TER		g Address (Street STEVENS						0.4.4
Baltimore,	ges 1 and 2 t of Health If item 27		20a. Method of Disposition 1 X Burial 2 Cremation 3 F	Compusi from State	Ce	metery, crer	sition (Name of natory or other place		Dat			on - City or 1	
i m	ment of transfer transfer in the first or o		* 4 ☐ Donation 5 ☐ Other (Specify)		BET		IEMORIAL						WN, MD
Bai	permit. Pag Department Important: I any injury o		21. Signatuse of Funeral Service Licens					., INC. , MD 21208					
Н			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ne cause on each li	ine.								Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	CER	EBI	ROVI	25 CUL	AR	TH	ROM	180.	515	
	Examiner			Due to (or as	a consequ	rence of):	45 CUL						Months
		ner	Sequentially list conditions, if any, reacing to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cras									
	ecuted and transi	Examiner		S									
8760,	ate be executed whysician and the burial-transit			Due to (or as	a consequ	rence or);							
9	the the	edical		3									
Вох	death certific e attending p ed for use as l	an/M	230. Was decedent pregnant	3c. If yes, outcome			Ectopic pregnancy	,				Date of deli	
O. E	0 0 0	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (specify)	· 				Month	Day Year
۵.	that the		Part II. Other significant conditions co.	ntributing to death b	out not resu	Iting in the u	nderlying cause giv	en in Part I.		23e. Did tob	acco use c	ontribute to	the cause of death?
rds,	w requires that the been signed by th should be detache	ed by								1 🗀 Ye:	s 2 🗆 No	3 □ Pro	obably 4 nknown
Vital Record	aw 2 s z	ompleted								24a. Was an	24	b. Were aut	topsy findings available ompletion of cause of
E R	The ste	Con								perform	ed? No	death?	2 🗆 No
Vita	Physician: Th this certificsteral director, pag	o Be	25. Was case referred to medical examiner?	fospital:			Ott	00 4		Check only one			
ō		\vdash	1 ☐ Yes 2 No '	28a. Date of this	irv	ER/Outpatien 28b. Time of	28c. Injur	y at		5 Resider			ify)
ion	Attending for death. ector: After by the funer.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ly Year)	Intury	M 1 🗆	k? Yes 2∐≀	No				
Division	of or Attendate after death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of tri building, et	ury - At hor c. (Specify	me, farm, str	eet, factory, office		281	f. Location (Str City or Town,		mber or Ru	ral Route Number,
	hours and hours		29a. Certifier 1 Certifying Phy	sician: To the best	of my knov	viedge, death	occurred at the tir	ne, date an	d place, and	d due to the ca	use(s) and	manner as	stated.
	To the Mospitel or a within 24 hours after To the Funerel Direction completely filled in b	Medical	(Check only 2 Medical Exami	ner: On the basis o and manner st	r examinati ated.	ion and/or in			th occurred				
	To To	-	29b. Signature and title of certifier				29c. Licens	9012	84	G 29	ru. Date sig	-16 -	Day, Year)
	12		30. Name and address of person who co	empleted cause of c	death (Item	23a) (Type,	Print)					110	2/204
	1 3.		A.H. GHILADI	MD.			SSLEVE	Di	r · 2.	owsu	NI	71	21204
: "	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 2 20		rar's Signat	ure	ash s						
		3 -	AUIA M W FO	200 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	STATE OF STATE OF	for the same	San Bay						

	Physici	an	Prizes	H.M.	Grif	fin				Month	Da	ay Year	1.4
	/Medi		Bryan		GLII	. 1 111	45 O'S T	.1		anuary		, 2008	2:00 a [™]
	Examir	er	4a. Facility Name (If not institution, gi				4b. City, Town, o	rLocation	of Death		40	c. County of Dea	
			103 Nee1 Avenu 5. Social Security Number 6.		je (In yrs. las	t histheles d	Reis If Under 1 Year	terst If Under		Date of Birt	11-	_Baltim	
	Funeral			15⊈M 2□F		Yrs.	Months Days	Hours	Min.	(Month, Da	y, Year) (rthplace (State or Foreign Country)
26	Director		216-44-4638	71	62	110.			Aι	ıg 10,	19	45	Baltimore
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City. 7	Fown or Loc	eation						10d. Inside City Limits
	aryle sho sho	'n			,,,,								1 □ Yes 2√□ No
	8a-f	Director	MD Balti	more		Kels	terstown						
	or 2	iż	10e. Street and Number				10f. Zip Code			ì	10g. C	itizen of What C	Country?
	th w 23a ust b		103 Nee1 Av	enue			2	1136				U.S.A.	
	ems er m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	as Decedent of H Yes, specify Cuba	lispanic Or	rigin? (Specifi	Yes or No	-	14. Race - Am Black, Wh	erican Indian,
ဖွ	or it		1 ☐ Never Married 2 ☑ Married	1 Yes 2 ☐	No		☐ Yes 2☑ No			un, 010.)			nte, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				Opechy				Specify:	White
2	72 honatu	Completed	15. Decedent's E (Specify only highest gi			16a. Deced	ent's Usual Occup	ation	et of working		16b. l	Kind of Busines	s/Industry
2	thin e.	鱼	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. E	kind of work done OO NOT use retired	d)	st of working	,			
7	d wil	ő		4		Bu	siness A	gent			Te	amster	Union
þ	oth of the	Be (17. Father's Name (First, Middle, Las	t)				18. Moth	er's Name <i>(F</i>	irst, Middle,	Maide	n Surname)	
<u>a</u>	lid by lenta ked	To E	Charles	G. Griff:	in				F	lita	C.	Dayhoff	
2	shound No		19a. Informant's Name/Relationship			19b. Mailin	g Address (Street	and Numb					Zip Code)
Maryland	od 2 Ith a 27 is		Mary Louise Grif:	fin Wife	- 1		eel Aven				-		, ,
a)	Hear Hem		20a. Method of Disposition	rin wire	20b. Plac	e of Dispos	sition (Name of	i	Date	SLOWN	20c. l	aryland Location - City o	r Town, State
0	ages intol		1 ☐ Burial 2 ☐ Cremation 3 [natory or other plac	i					
≣	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		Carr		remation Name and Addre						, Maryland
Baltimore,	permi Depa Impo any Ir		21. Signature of Pullerar Service Lice	ensee					, 110			erstown	
_	20 - 10 0		Janes (tine			INE FUNE					own, MD	21136
83		1	23a. Fart1. Enter the disease, or cor hock, or heart failure. List only	one cause on each li	ne.			•			,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Adens	CATCU	nom c	of un	corta	in pri	mary			Onset and Death
7	/Medical		resulting in death)	Due to (or as	a conseque	nce of):			1				
	Examiner		Cognestially list conditions	b									
Ш	D-41	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	nce of):							
	cuted od ransi	Examiner	that initiated events	C.									
ó	an ar rial-t		resulting in death) Last	Due to (or as	a consequer	nce of):							
Box 68760,	death certificate be executed a attending physician and d for use as the burial-transit	Physician/Medical		d				_					
89	g ph as th	edi									-		
ŏ	n cer andin use	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of d	elivery
Ω.	deat d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant a			Ectopic pregnancy Other (specify)	у				Month	Day Year
P.O.	w requires that the de been signed by the a should be detached	hys	9 □ Unknown	9Ll Unknown									
П.	The law requires that the ste has been signed by thoage 2 should be detache		Part II. Other significant conditions	contributing to death b	ut not resulti	ng in the un	derlying cause giv	en in Part	I.	23e. Did t	obacco	use contribute	to the cause of death?
ģ	luires Id be	d by	Pulmonary emb	olism						1 🗆 '	Yes :	2 1 1√10 3 1 1	Probably 4 ☐Unknown
2	v rec beel shou	Completed	D000 11	wombos	2 1					24a. Was	00	Odb Wore	autonou findinan ausilahla
Be	has ge 2	ш	need remore	MO14/1202	12					auto		prior to	autopsy findings available completion of cause of
a				1				_		1□ Yes	2 - N		
₹	Physician: The la this certificate haveral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:			3 DOA Oth		e of Death (C	heck only o	ne)		
ō	Phys this aldia	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie		R/Outpatien	OL DOX	4 L N				6 □Other (Sp	pecify)
_	Attending Physician: r death. ector: After this certifics by the funeral director, p	o	1 ☑Natural 5 ☐ Pending	(Month, Da		8b. Time of Injury	28c. Injur Wor			i. Describe i	now inj	ury occurred	
Si	tend leath tor: the	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not I		***			Yes 2					
Division or Vital Records,	or Al fter c Sirec in by	Certification:	4 ☐ Homicide determined	28e. Place of Inj	ury - At nome ic. <i>(Specify)</i>	e, tarm, stre	et, factory, office		281.	City or To	Street a wn, Sta	and Number or i te)	Rural Route Number,
	ospital hours a uneral [
	Hosp 4 hor Fune Fely fi	ical	(Check only 2 Medical Exa	hysician: To the best uminer: On the basis o	of examination	edge, death n and/or in\	occurred at the tile restigation, in my o	me, date a opinion, de	and place, and eath occurred	due to the at the time,	cause(date a	s) and manner and place, and d	as stated. ue to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	one)	and manner st	ated.								
	6 ₹ ₹ 9	-	29b. Signature and title of certifier				29c. Licens				29a. D	ate signed (Mo	ntn, Day, Year)
	~,		5 pters	Deer			De	0533	37		\	114108	
C	11		30. Name and address of person who	completed sause of c	death (Item 2	3a) (Type, I			0.4.1				
0	1 /		2835 Smith A			03	Baltin	de,	Myg	1200	\		
	Sta		31. Date filed (Month, Day, Year)	32. Registr	rar's Signatur								
	Regist	ar	IAN 2 2 2	008	. M	1	sell)						
DHI	MH 17 Rev 1/2	001	Cities to to	Jacob.	rdir giran	A STATE OF THE PARTY OF THE PAR	Serve (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last)

Reg. No. 2

Date of Death Month

		For State Registrar	State of M		d / Depa		of H	ealth	and M	_		200	8 01063		
Physicia /Medic		1. Decedent's Name (First, Middle	ent Graffiu	s						2. Date of De	eath	<u> 0 0</u>	3. Time of Death		
Examin		4a. Facility Name (If not institution	n, give street and number) PDH MECICA	l Cer	nter	4b. City,						County of D	altimore		
Funeral Director		5. Social Security Number 217-38-8180 Usual Residence of Decedent	6. Sex 7. Ag 1 ☑ M 2 ☐ F	ge (In yrs. I 65	as <i>t birthd</i> ay) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Nov . 1	ay, Year)		Birthplace (State or Foreign Country) PA		
e Maryland a-f show tifled at	ctor	10a. State 10b. County	imore		sex	cation							10d. Inside City Limits 1 ☐ Yes 2 █️No		
th with the 23a or 28 ist be no	al Director	10e. Street and Number 728 Essex	Avenue			10f. Zip		221			-	zen of What SA	: Country?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2√2 Mar 3 □ Widowed 4 □ Divorced	If Yes, Give)		Was Deced f Yes, spec l ☐ Yes 2		ispanic Oi in, Mexica Specify		ecify Yes or No Rican, etc.)	0-	Black, W	merican Indian, Vhite, etc. White		
within 72 ho sne. than "natur ne Medical (Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-4or	5+)		dent's Usua kind of wor DO NOT us hani	k done d e retired	ation during mos	st of work	ing	ess/Industry				
be filed value of other sevent, tr	Be	12th 17. Father's Name (First, Middle						18. Moth		Auto me (First, Middle, Maiden Surname)					
d 2 should th and Mer 7 is marke traumatic	Page 19 Walter A. Graffius Page 19 Page 1											r Town, Stat	te, Zip Code)		
1 and Healt Healt Sther	Charlotte Graffius / wife 728 Essex Avenue Balti												or Town, State		
it. Pages artment of ortant: If II injury or o		1 ☐ Bunal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3	Specify)	Ba	wiewery, crer	Cre Characteristics Cre Characteristics			1/2	1/08	В	altim	ore MD		
permi Depa Impo any ir once		Coluf	Yelly Cornel	ly	6				3 (alto. MD x 21221		
Physician /Medical Examiner		23a. Parti Enter the disease, o shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death)	RESP Due to (or as	I RAT	ORY F	AILU	RE			or respiratory a	arrest,		Approximate interval Between Onset and Death		
@ <u>_</u>	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as I SCH Due to (or as	EMIC	CARD										
The law requires that the death certificate be ate has been signed by the aftending physici page 2 should be detached for use as the bu	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	Ideath 3□	Ectopic production of the second seco						23d. Date of Month	delivery Day Year		
quires that n signed b	d by Pi	Part II. Other significant condit DIABETES	ions contributing to death t	out not resu	ulting in the u	nderlying ca	ause give	en in Part	i.		tobacco (te to the cause of death? ¶ Probably 4 □Unknown		
: The law requir cate has been si ; page 2 should i	DIABETES 1 Yes 2 No 3 Probably 4 Unknow 24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 3 Probably 4 Unknow										th?				
siciar certif rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		===/a:		Δ Oth	or:		h (Check only					
ding Phy: h. After this tuneral di	tion: To	27. Manner of Death 1 Natural 5 □ Pendi	28a. Date of Inj	ury	ER/Outpatier 28b. Time of Injury		8c. Injun Worl	4 L N		ome 5 Res 28d. Describe			Specify)		
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director, After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident Invest 3 Suicide 6 Could 4 Homicide detern	not be 28e. Place of in	jury - At ho tc. (Specif)	ome, farm, str					28f. Location City or To	(Street ar own, State	nd Number o	or Rural Route Number,		
ne Hospi n 24 houn ne Funer pletely fill	Medical		ing Physician: To the best i Examiner: On the basis and manner s	of examina											
To the within comp	Me	29b. Signature and title of certific	er [L. Lui	this	1111	290		e number 1826	3			te signed (N	fonth, Day, Year)		
8		30. Name and address of person	n who completed cause of				SLE	R DI	RIVE	TOWS			AND 21204		
Sta Registr		31. Date filed (Month, Day, Year	2009	rar's Signa	ture	46/2									

State Registrar DHMH 17 Rev 1/2001

	00534 n Joseph Ge	ndin	Please Type on State	or Print in BI of Maryland									000	0.1	
			1- For State Registrar			icate of						, No. 2	008	0	106
Ma	Physicia dical Exami		Decedent's Name (First, Middle,Las	,						-	Date of Death Month	Day Ye		Time of De	
Med	ulcai ⊨xami	ner	John J. 4a. Facility Name (if not institution, give	Gendime			4b. City, To	wn or L	ocation of		January 19	, 2008 4c. County	of Death	03011118	<u></u>
4			Franklin Square Hospital	e street and number)			Roseda		obdition of	Dodan		1	re Count	У	
	Funeral		5. Social Security Number 6. S	ex 7. Ag	e (In yrs. last	birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of Birth	(MM/DD/YYY	y) 9. Birthp	lace (State	or
	Director		215-80-9428	M 2 F	4	6 Yrs	Months i.	Days	Hours	Min.	Oct.3	0,1961	Foreign Coun	try) M]	D
			Usual Residence of Decedent				-	1		LL					
	w any		10a. State 10b. County		10c. City, To								- 1	0d. Inside C	
	yland a-f sho t once	햙	MD Baltim 10e. Street and Number	ore 	ĪΛĪ	iddle	10f. Zip C			_	110	g. Citizen of W			
	vith the Maryland s 23a or 28a-f show a e notified at once.	Director	1538 Becklow	Avenue			101. Zip C	212	20		10	USA	mat Count	y :	
	with the s 23a e noti		11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	s Deceden			n? (Spec	ify Yes or No-		e - America	n Indian, Bla	ack,
	leath r r item	unera	1 Never Married 2 Married	Armed Forces?	X _{No}		es, specify					Whi	te, etc.		
	after (by F		If Yes, Give Yeer or Dates:		1	Yes 2	₹ No	specify:			Specify:	Whi	te	
	hours natur Exam	ed	15. Decedent's Education (Specify of			6a. Deceden during m	nt's Usual O nost of work					16b. Kind of B	usiness/Ind	lustry	
	36 iin 72 ihan "dical	ompleted	Elementary/Secondary (0-12) 12th	College (1-4 or	5+)	Too]	l Mak	er				Mart	in M	arie	tta
	5-0036 led within 7 Hygiene. I other than	Com	17. Father's Name (First, Middle, Last)				1	8.Mother's	Name (F	irst, Middle, M	laiden Surnam	e)		
	21215 ould be file Mental H marked c	Be (Joseph D. Gen	dimenico					Car	mel	a Mira	anda			
	21 hould and Mer is man	ို	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or								-				
	MD nd 2 sho alth and m 27 is		Janet Keatley 20a. Method of Disposition	/ sist		991 ice of Dispos		ieca	Par	k R	oad Ba	altimo	ore M	D 21	220
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ч	1 Burial 2 X Cremation 3	Removal from St						-			imor	·	
	timent transition of or of		1												
	Bal Permi Depar Impo		21. Signature of Funeral Service Lice	nsee y	1.	22.	Toppo	address	or Facility	300	Mace	Ave.	Balt	imore	e MD
	Physician		23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging											Approximat	te Interval
4	/Medical vaminer													Between O	
Ž	Caltillet		or condition resulting in death) Due to (or as a consequence of):												
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):										
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated												
	ted J Insit	Exa	events resulting in death) Last	Due to (or as a cons	equence of):										
	cords, P.O. Box 68760, law requires that the death certificate be execute has been signed by the attending physician and 2. Should be detached for use as the burial - tran	ical	UNPENDED	AMENDED											
	60, ate be ohysici te buri	cian/Medical	IF FEMALE:	23c. If yes, outco	me of pregna	ncy						23d. Date	of delivery		
	68760, certificate be nding physic se as the bur	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	t time of deat	h -	etal death	3	Ectopic	pregnand	су	Month	Da	ıy	Year
	Box e death c the atten ed for us	Physic	1 Yes 2 No 9 Unknow	the state of the s	t time or death	n 5 O	ther (Speci	ify)				1			
	Records, P.O. Box 68760, The law requires that the death certificate be cate has been signed by the attending physici page 2 should be detached for use as the burit		Part II. Other significant conditions	contributing to dear	th but not resi	ulting in the	underlying	cause gi	iven in Par	t I.	23e. Did to	bacco use cor	tribute to th	ne cause of	death?
	ires th signer lbe de	d by									1 Yes	2 🗸 No	3 Proba	ibly 4 L	Jnknown
	ords w requ	Completed									24a. Was autop		prior to co	opsy findings impletion of	
	Reco	mo										med? 2 ✔ No	death?	2	No
	ian: 7	25. Was case referred to medical examiner?							of Death (Check on	ly one)				
	ivision of Vital Records, or Attending Physician: The law requiralter death. Director: After this certificate has been s in by the funeral director, page 2 should I	ToE	1 ✔ Yes 2 No		ent 2 🗸 E			,,				Residence 6			
	_ = ≛ . ^ ≥	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inj FOUND:	ury Year) 2	8b. Time of FOUND:	injury 2		yat Work? ′es 2 ✔	ls.	ubject han	now injury occu ged self	ured		
	Division tal or Attending as after death. Tal Director: ded in by the fu	icati	2 Accident Investiga	28e Place of I		0215 hrs ne, farm, stre	eet, factory.				28f. Location (Street and Number or Rural Route Number, City				mber, City
	Divis	ertification:	3 ✓ Suicide 6 Could no determine	t be			,	330 01			or Town, S	tate)			,,
	# 4 F 1	ပ	29a. Certifier 1 Certifying Physic	cian: To the best of n	ny knowledge	, death occu	urred at the	time, da	te and plac	18 South Essex Avenue, Essex, MD ice, and due to the cause(s) and manner as stated.					
	To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examine	er: On the basis of exa	amination and	l/or investiga				curred at t	the time, date	,			
	->-0	ž	29b. Signature and title of certifier				29c.	. License	e number			29d. Date si	gned (Mon	th, Day, Year	7

Dir To the Hospital of within 24 hours at To the Funeral I

27

OCME

Mary G. Hople MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year)

30. Name and ad , ss of serson who completed cause of death (Item 23a)

32 Registrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

January 19, 2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ roi	partment of Health and Mental Hy	giene Reg. N2 008 01065			
			Decedent's Name (First, Middle, Last)	2. Date of D	eath 3. Time of Death			
	Physicial Physicial Physician/Medical Physician		Reed Albert Greninger	Januar	y 16, 2008 11:25 P M			
100	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death			
<u>, 1</u>			National Lutheran Home	Rockville	montgomery 9. Birthplace (State or Foreign			
	Funeral Director	X)	5. Social Security Number 6. Sex 1 ≤ N 2 □ F 7. Age (In yrs. last birthda 2 □ F 92 Yrs.	Months Days Hours Min. (Month, Day				
35	ס		Usuaf Residence of Decedent	reb.	27, 1915 Pennsylvania			
9	arylan show	1	10a. State 10b. County 10c. City, Town or	Location	10d. fnside City Limits			
	Be-f	ecto	Virginia Fairfax	1.00.20	1x□xYes 2□No			
	with t	Funeral Directo	10e. Street and Number 10133 Spring Lake Terrace	10f. Zip Code 22030	10g. Citizen of What Country? U.S.A			
	ns 23	era	11 Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Specify Yes or N	o- 14. Race - American Indian,			
	or Ita	Fur	Armed Forces? 1 ☐ Never Married 2€XMarried Armed Forces? 1 ☐ Yes, 25€ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:	Black, White, etc.			
003	within 72 hours after death with the Maryland ene. than 'natural', or itams 23e or 28e-f ehow he Mudical Exercit er must be indiffed at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: White			
21215-0036	n 72 i	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired)	16b. Kind of Business/Industry			
212	iene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	rgy	Lutheran Faith			
פ	e filed al Hyg othe vant,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middl				
ylaı	Menta Menta arked	To E	Harry Vernon Greninger	Laura Douty				
Maryland	12 sh h and 7 is m reum		W 1 11 P P P 1	ailing Address (Street and Number or Rural Route Num	64 - 1805041			
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural; or Itams 23a or 28e-f show any injury or other traumatic avant, the Mudical Exactive must be collided at ODGe.		20a. Method of Disposition 20b. Place of Dis	3 Spring Lake Terrace, Fa	irfax, VA 22030 20c. Location - City or Town, State			
Baltimore,	Pages ent of nt: If It		1 & Burial 2 Cremation 3 Removal from State	inematory or other place) January	7			
a E	mit. F pertmi portar 7 injus		21. Signature of Princial Service Licensee	wn Memorial 22, 2008 22. Name and Address of Facility	Farmingdale, NY 171 W. Maple Ave.			
<u>~</u>	Depe Impo any is		Mo0968	Money & King Funeral Home				
. *			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Finaf disease or condition resulting in death)		10 days			
	/Medical Examiner		Due to (or as a consequence of):		6-			
		er	Sequentially list conditions, b. Due to (or as a consequence of):					
K	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.					
o, O	ate be executed thysiclen and the burial-transit		resulting in death) Last Due to (or as a consequence of):					
8760,		dical	d					
9 x	es that the death certific igned by the ettending p be detached for use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery			
Вох	death	clar	1 Ves 2 No. 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	Month Day Year			
0	t the by the tacher	hys	9 Unknown					
S,	es tha igned be de	by F	Part fl. Dther significant conditions contributing to death but not resulting in the	. 44 . 2	tobacco use contribute to the cause of death?			
ord	w require been sig should b	Completed	The court were of the	a di affremity	Yes 2 140 3 Probably 4 Unknown			
Records,	hes the	mpl	e sent vas auar alse	24a. We aut	s an 24b. Were autopsy findings available prior to completion of cause of death?			
a	in: Th		25. Was case referred to medical	1 ☐ Yes	2 No 1 Yes 2 No			
f Vital	yeicle is cert direct	To Be	examiner? 1 Yes 2 Mo	26. Place of Death (Check only item 3 □ DOA Other: 4 A Hirsing Home 5 □ Re				
Division of	ding Phyeiclen: The I h. After this certificate he funeral director, page		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	of 28c. fnjury at 28d. Describe	how infury occurred			
Sio	tendi Jeath. tor: A the fu	cati	2 Accident investigation	M 1 Yes 2 No				
$\frac{1}{2}$	after of Dirac	Certification:	4 Homicide	street, factory, office 281. Location City or T	(Street and Number or Rural Route Number, own, State)			
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the		29a. Certifier 1 Decrtifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and due to the	e cause(s) and manner as stated.			
	ne Ho n 24 h ne Fu	Medical	(Check only and manner stated.	r investigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)			
	with To t	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)			
•	£		Menles W. Kersch	7 12/1/26	Hanuary 17, 2008			
	H		30. Name and address of person who completed cause of death (ftem 23a) (Type Charles W. Karesh, M.D., 26033 Ridge		od 20872			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,c noau, bamascus, marylan	IQ 20072			
10 mg	Regist		JAN 2 2 2008 1	South .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health an rtificate of Death	2.0	2000 01066
	4 7 7 1	10	Registrar 1. Decedent's Name (First, Middle, Last)	Timeate of Beatif	Reg. No	3. Time of Death
	Physici	_	CAROLINE MYERS GWYNN		Month Da	
A STATE OF	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of D		c. County of Death
1	LAGIIII	3	KESWICK MULTI CENTER	BALTIMORE		N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	Hrs. 8. Date of Birth (Month, Day, Year,	9 Birthplace (State or Foreign
	Director		220-50-3235 1□ M 2፟ØF 86 Yrs.	World Bays Hours	SEPT 29 19	921 MARYLAND
	w w]	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	f sho	5		PERRYHALL		1 ☐ Yes 2 🛣 No
	the 28a-	Director	MARYLAND BALTIMORE 10e. Street and Number	10f. Zip Code	10g. Ci	itizen of What Country?
	3a or	0	4806 FORGE RD.	21128		U.S.A.
	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.
9	after or ite mine	F	1 □ Never Married 2 ⚠ Married 1 □ Yes 2 ☒ No	1 ☐ Yes 2 ☑ No Specify:	derio i noan, etc.)	Specific:
003	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notifiled at	d b	3 Widowed 4 Divorced Year or Dates:			BLACK
21215-0036	"nat	Completed by	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	working	Kind of Business/Industry
12	within iene. than "	ᇤ	Elementary/Secondary (0-12) College (1-4or 5+)	MEMAKER		PRIVATE
p	Hyg Hyg other ent, 1	Be C	17. Father's Name (First, Middle, Last)		Name (First, Middle, Maide	n Surname)
Jan	Alenta Alenta rked tic ev	To B	CARVEL MYERS	ELIZA	ABETH BROWN M	YERS
Maryland	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " raumatic event, the Med	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ing Address (Street and Number of	r Rural Route Number, City	or Town, State, Zip Code)
Σ.	and and and n 27 in 27 in ear tra			Turnberry Ct.,		
ore	Pages 1 Hent of H Int: If iter Iny or oth		20a. Method of Disposition 1	osition (Name of ematory or other place)	Date 20c. L	Location - City or Town, State
Ë	Ement tant: jury		4 □ Dopation 5 □ Other (Specify) ASBURY			ITE MARSH, MARYLAND
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: In the marked other than "natural", or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility WILLIAM C BROWN 321 S PHILADELPI	COMMUNITY FU	NERAL HOME P.A. RDEEN, MD 21001
			23a, Part1, Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as ca	rdiac or respiratory arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition a.a. DIABET	FS MEIIIT	US Type	Onset and Death
7	/Medical Examiner		Due to (or as a consequence of):			
	(a s	<u>.</u>	Sequentially list conditions, Due to jor as a consequence of the conditions of the			
\sqrt{J}	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury			
o,	executed in and ial-transit		that initiated events c			
8760,	certificate be executed Iding physician and Ise as the burial-transit	dical	d			
9	rtifica ng ph as th	Med	IF FEMALE:			
Вох	death certifice e attending phed for use as the	an/I	23h Was decedent pregnant 23c. If yes, outcome pt pregnancy	□Ectopic pregnancy		23d. Date of delivery Month Day Year
	ne de the a hed fe	Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		mona. Day roa
P.0.	w requires that the de been signed by the should be detached	문	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ds,	uires sign	Completed by	peripheral vascular o	ISEUSE	1 ☐ Yes	2 No 3 Probably 4 Unknown
00	w req	ete	demensia - multiu	nFAVCT	24a. Was an	24b. Were autopsy findings available
Be	The law te has b	l di	- CHICKEN THE COLUMN		autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
ital	lan: 'rtifical	Be C	25. Was case referred to medical	26. Place of	1 Yes 2 N Death (Check only one)	No 1 ☐ Yes 2 ☐ No
r <	Physician; this certifical	To B	examiner? 1 ☐ Yes 2 7 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursi	ng Home 5 ☐ Residence	6 □Other (Specify)
u o	ng Pl fter th	ü	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury	of 28c. Injury at Work?	28d. Describe how inju	ury occurred
sio	tend eath. tor: / the fu	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	,	
Division or Vital Records,	offer death. I Director: After d n by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
-	Hospital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and	l place, and due to the cause((s) and manner as stated.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Uncertor: After this certificate has completely filled in by the funeral director, page 2.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death	occurred at the time, date a	ind place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
			huanu am us	D 351	02 Jan	nuary 18 2008
	B		30. Name and address of person who completed cause of death (Item 23a) (Type			
	7			orth Charle	5 ITTILL D	altimore Marylani
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	and the state of		,

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	iryiand /		riment of H tificate of L				2008	01067
P	Physicia		1. Decedent's Name (First, Middle, La BARBARA C.						2. Date of De Month Januar	Day	Year 2008	3. Time of Death 2:00 a M
	/Medic Examin	Cal the City Town or Legation of Deciti					Ounau		County of Death			
			15812 Joyce Lan	е	Laurel 7. Age (In yrs. last birthday) Yrs. Laurel If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					Prin		eorge's
	Funeral Director		5. Social Security Number 6. S 218-66-4602 Usual Residence of Decedent	6ex 7. Age □ M 2]X F					(Month, Day, Year)			place (State or Foreign intry) nington, DC
	ryland thow	Director	10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2X No
	8a-f s		MD Prince	George's	Laure	<u> </u>				10 000		
	with the		10e. Street and Number				10f. Zip Code				zen of What Cou	ıntry'?
	ns 23	Funeral	15812 Joyce Land	12. Was Decedent B	ever in U.S.	13. V	20707 Vas Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		SA 14. Race - Amer	ican Indian,
9500-61	be filed within 72 hours after death with the Maryland and Hygliene. It hygliene dither than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ XN If Yes, Give Year or Dates:			Yes, specify Cuba		Rican, etc.)		Black, White	, etc. nite
בָּ ב	72 ho natur	eted	15. Decedent's E	ducation	16	Sa. Deced	ent's Usual Occup	ation during most of work	ina	16b. Ki	nd of Business/I	ndustry
Ž	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5				during most of work	9		3	
7	filed w Hygien other th		12th 17. Father's Name (First, Middle, Last	2		l'echr	nical Ill	18. Mother's Name	e (First Middle		Governme	ent
Maryland	d be fantal H	Be	George W. Rame:						a M. Ba:		<i>Cumamo</i>	
<u></u>	should be f and Mental I s marked of umatic eve	은	19a. Informant's Name/Relationship (19	9b. Mailin	g Address (Street	and Number or Rui			or Town, State, Z	ip Code)
	nd 2 alth a 27 is 27 is		Frank Giambrone/H	usband		1581	.2 Joyce	Lane, Lau	irel, M	D 20	0707	
gaitimore,	permit. Pages 1 a Department of Hee Important: If Item any Injury or othe		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			of Dispos tery, crem	sition (Name of natory or other place ndel Crem	ce)	Date	20c. Lo	ocation - City or I	
a	partm portal y inju		21. Signature of Funeral Service Lice				. Name and Addres	ss of Facility Don	naldson	Fune	eral Hom	ne, P.A.
מ	8 3 E 6		ances	& BOOK	M01103			t Avenue			D 20707	
			23a. Part1. F te the disease, or com shock, or leart failure. List only	plications that caused one cause on each lir	the death. De	o not ente	er the mode of dyin	g, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Code (Final disease or condition resulting in death)	a. Sep								
	/Medical Examiner	er	resulting in death)	Due to (or as								
- 3.	\$1		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Bladder Cancer Due to (or as a consequence of):									
if any, leading to immediate cause. Enter Underlying Cause. (Disease of high) that imitiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):												
oʻ	exec an and rial-tra		resulting in death) Last	Due to (or as	a consequenc	e of):						
5876 0,	ificate be executed g physician and as the burial-transit	edical		_ d								
	ertifica ing ph e as ti		IF FEMALE:									
X Q Q	w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		Ectopic pregnancy Other (specify)	1			23d. Date of deli Month	very Day Year
j.	the d	ysic	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□Unknown	time of death		Curici (speemy) _					
7.	s that ned by deta	Completed by Ph	Part II. Other significant conditions	contributing to death bu	ut not resulting	g in the un	nderlying cause give	en in Part I.	23e. Did	tobacco u	use contribute to	the cause of death?
ğ	equire en sig		Multiple Scler	osis					10	Yes 2	No 3□ Pro	obably 4 □Unknown
Vital Records,	sician: The law re certificate has bee irector, page 2 sho								24a. Was auto perfe 1∐ Yes	psy ormed?	death?	topsy findings available completion of cause of
<u>a</u>	₩ □	Be C	25. Was case referred to medical examiner?					26. Place of Deat			7 12100	
_	his la	ToE	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie				4 ☐ Nursing Ho			6 □Other (Spec	city)
ם ב	ding Ph n. After th funeral		27. Manner of Death XXNatural 5 ☐ Pending	28a. Date of Inju (Month, Day		o. Time of Injury	Wor		28d. Describe	how injur	ry occurred	
Uivision	death ctor: ,	icati	2 Accident investigatio 3 Suicide 6 Could not b	e 280 Place of inju	ırv - At home.	farm, stre	M 1 □	Yes 2 □ No	28f. Location	Street an	nd Number or Ru	ral Route Number,
2	pital or Al ours after d leral Direc filled in by	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	. , .	7,		City or To	wn, State	9)	
	To the Hospital or Attending P within 24 hours after ceath. To the Funeral Director. After t completely filled in by the funera	Medical C		hysician: To the best of miner: On the basis of and manner sta	examination							
		Me	29b. Signature and title of certifier			-	29c. Licens	e number		29d. Da	te signed (Monti	n, Day, Year)
			D/ when .	OG			1466	6605		01	18/08	Ž
, 4	T		30. Name and address of person who	completed cause of d	eath (Item 23a	a) (Type, I		_ /		A 4 J	N	
1	/		DONULESKUSKI, 31. Date filed (Month, Day, Year)	DO C	1200		usil C	1, La	190	1~1	7	
	Sta Registr		JAN 2 2 200	32. Registra	ar's Signature	Con	وع		•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) MARIE FRANCES GRIFFITH Day Year Physician ,2008 JANUARY 17 8:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCHRIST HOSPICE CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1-15-1923 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2 ☑ F 85 Yrs. MARYLAND 214-16-9827 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE MIDDLE RIVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 705 COMPASS ROAD APT. 227 U.S.A. death v Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) a a CONTINENTAL CAN PLASTICS traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked or any injury or other traumatic ev WOLF CARL ERICH JULIA (SMITH) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23356 EDWARD WOLF BROTHER 2194 JOLLY RODGER DR. GREENBACKVILLE, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 1-22-2008 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Wreks preumonia /Medical Due to (or as a consequence of): Examiner Obstructure years MIL Wolinguary Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-tran The law requires that the death certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No page 2 performed? autonsy 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify NO SPLC) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 | Inpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Hospital or Attending Physician: 24 hours a e Funeral I within 24 hor To the Fune completely fi

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J CHARLES W)

and manner stated.

6701 N- Chances ST TONSON MD 2120

29d. Date signed (Month, Day, Year)

January 18 2008

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2008

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** II: ZIPM 18 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL MOSPITAL TIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) -46-2580 Months Days 1 □ M 2 💢 F Hours Director MARCH IRGINIA Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 'natural", or Items 23a or other traumatic event, the Medical Examiner must be filed within 72 hours after death the Hygiene. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) ISOR AUNDRY TEXTILE SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MOSES ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City of Town, State Department of Important; If II any Injury or o 1∕≰Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MARYLAND 21. Signat of Funeral Service Liçensee JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or any my Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed end stage
Due to (or as a consequence of): physician and s the burial-trans Records, P.O. Box 68760; Physician/Medical attending I IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has tirector, page 2 s autopsy perform or Vital 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 10 2 ER/Outpatient 3 DOA 1 Impatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation Hospital or Attending 1 Natural I hours after death.

Uneral Director: At all filled in by the further 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after
To the Funeral Direcompletely filled in b 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2438946 eint. MD 2008 19 th 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Elie

31. Date filed (Month, Day, Year)

unio

МΟ

32. Régistrar's Signature

haspital

08-00486 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William Hubbard State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 17, 2008 1440 hrs Medical Examiner William Samuel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Harford Harford Memorial Hospital Havre de Grace 5. Social Security Number 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth/MM/DD/YYYY **Funeral** Months Director Days Hours Min 157.26.676 1 XM Country) Usual Residence of Decedent 10d. Inside City Limits Inv 10c. City, Town or Location Aberdeer Harford 28a-f show 1 Yes 2 No MD traumatic event, the Medical Examiner must be notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Director 10e. Street and Number 10g. Citizen of What Country? 21001 3505 Churchville or items 23a or Funeral 11. Marital Status . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces?

1 Yes 2 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Black Yes 2 X No specify: Widowed Divorced Yes, Give Year Specify: If item 27 is marked other than "natural", þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Highter tire 18.Mother's Name (First, Middle, Maiden Surname Be Hubbard ander edla. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Churchville 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date or other crematory or other place) 1 X Burial 2 Cremation 3 01.25.08 emorial. important: Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service License Vanahn and all stonin MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): e attending physician and for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown signed by the Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 V No 3 Probably 4 Diabetes Mellitus Director: After this certificate has been a 1 in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has death? performed? 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medica 26.Place of Death (Check only one) Be Other₄ Hospital: 4 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 No Pending hours after death. Accident Investigation completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined To the Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) O.C.M.E. January 18, 2008 a Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month HOOD **Physician** VERNON 2008 7.05PM 12 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HABOR HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Funeral 1⊠M 2□F Months Days Hours Min 67 Yrs Aug 16, 214-36-3026 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1√2 Yes 2 □ No Director MD Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3603 Brooklyn Avenue 21225 USA by Funeral 12. Was Decedent Ever in U.Sunk
Armed Forces?

1 □ Yes 2 □ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □ Yes 2 ☒ No Specify: 14. Race - American Indian, unk Black, White, etc. 1 □ Never Married 2 □ Married Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education unk unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harbor Hospital 3001 S. Hanover Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5☒Other(Specify) in state 21. Si nature of Funeral Service Licensee Ronald S. W. d. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 7D/irector 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Examiner The law requires that the death curtificate be executed the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ttending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ upertension 1 Yes 2 No 3 Probably 4 Unknown Completed disease 24b. Were autopsy findings available prior to completion of cause of death? Loronar 24a. Was an has autopsy perform certificate 2□ No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 000 January 12 2008 Mamatt 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DR Mamatha Prabhakar, 3001, 9. Hanover street, Baltimore, MD - 21225 32. Régistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JAN 2 2

books)

08-00262 Coleman Hackett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

leman Hackett	1-	State of Maryland / Department of For State Certificate of	Health and Mental Hy Death	giene Reg. No. 2008 0107			
Physician		eqistrar . Decedent's Name (First, Middle,Last)		2. Date of Death 3. Time of Death Month Day Year 1000 Level			
edical Examine	er	COleman Hackett		January 9, 2008			
f	4	a. Facility Name (ii flot institution, give exists and member)	b. City, Town, or Location of Death Baltimore	4c. County of Death			
•		Sinai Hospital		8. Date of Birth(MM/DD/YYYY) g. Birthplace (State or			
Funeral	5	Social Security Number unk 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	Foreign			
Director	L	1XM 2 F 66 Yrs		May 31, 1941 Country)			
à à		Java Residence of Decedent	on	unk 10d. Inside City Limits			
	.	unik		unk 1 Yes 2 No			
nrylan Ba-f sl	휭	10e. Street and Number unk	10f. Zip Code	unk 10g. Citizen of What Country?			
with the Maryland ns 23a or 28a-f shu or notified at once	Director			USA			
with 1		Armod Foresco 11nk lift	is Decedent of Hispanic Origin? (Spress, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.			
rs after death with the Maryland ural", or items 23a or 28a-f show any miret, must be notified at once.	Funeral	1 Never Married 2 Marned 1 Yes 2 No	1				
after ral",	<u>a</u>	or Dates:	Yes 2 X No specify:	Specify: black work done unk 16b. Kind of Business/Industry unk			
hours natu	ᇍ	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use reti	(red)			
36 hin 72 e. than	힐	unk unk					
5-0036 led within 72 hou Tygiene Tygiene Tygiene Tygiene Tygiene Tygiene Tygiene	⊑ L	17. Father's Name (First, Middle, Last)	unk 18.Mother's Name	e (First, Middle, Maiden Sumame) unk			
215 be fill ntal F	å			Rural Route Number, City or Town, State, Zip Code)			
21 hould nd Me is ma	٩		Penn Street Bal	21221			
, MD and 2 sho ealth and em 27 is fraumati	-		sition (Name of cemetery,	Date 20c. Location - City or Town, State			
Baltimore, pernit. Pages I an Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crematory or c					
Eimert Frant:	-	4 Donation 5 X-other Specify: in state 21. Signature of Funeral Service Licensee 22.	Name and Address of Facility				
Balti permit. Departm Imports injury o	1	Ropeld S. Wade, Director IS	tate Anatomy Boa altimore, MD 21	rd 655 W. Baltimore Street			
Physician	+	23a, Part I. Enter the disease, or complications that caused the death. Do not enter	the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Interval Between Onset and			
ledical.		failure. List only one cause on each line. Immediate Cause (Final disease a. Cirrhosis of liver		Death			
aminer	- 1	or condition resulting in death) Due to (or as a consequence of):					
		Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):					
	in	cause. Enter Underlying Cause					
=	Examin	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
executed an and al - trans		d					
Sici be	edical	X UNPENDED AMENDED #23a,PII,27,perME,g876.	2/21/08 TT	23d. Date of delivery			
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	Ž	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregr	Year			
Box 6876 death certificate the attending phy of for use as the	Physician/M	A Distriction of the land of t	Other (Specify)				
Bo e deat the at	hys	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?			
, P.O. Be ires that the de signed by the		Emphysema, atherosclerotic cardiovascular		1 Yes 2 No 3 Probably 4 V Unknown			
Division of Vital Records, P.O ral or stending Physician: The law requires that t is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detax	Completed by	riiphyseia, atheroscrerotic tentrovascum	diede	24a. Was an 24b. Were autopsy findings available			
cords law requi has been	plet			autopsy prior to completion of cause of death?			
Rec The 1 icate P	, o	· · · · · · · · · · · · · · · · · · ·	26.Place of Death (Chec	1 Yes 2 No 1 Yes 2 No			
tal Recional The sector, page	Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient	Other:	sing Home 5 Residence 6 Other:			
f Vi Physi er this	မ	1 Yes 2 No Impater 2 Crosspan 27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe how injury occurred			
n of viding Ph. h. : After t	on:	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No				
ivisior or Attend after death. Director:	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Div	Certification:	3 Suicide 6 Could not be determined (Specify)		Ui Towii, State)			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a Certifier . To disc. But it is To the heat of my knowledge death or	curred at the time, date and place, a	and due to the cause(s) and manner as stated.			
o the ithin 2 o the	Medical	one) 2 Medical Examiner:On the basis of examination and/or invest and manner stated.		on, death occurred at the time, date and place, and due to the cause(s)			
E 2 E 8	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year) January 10, 2008			
		Poter Unon - Hollohus	O.C.M.E.	January 10, 2000			
		30. Name and address of person who completed cause of death (Item 23a)	111 Penn Street, Baltim	nore. MD 21201			
		Patricia Aronica-Pollak MD. Assistant Medical Examine	2711				
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	and s				

e Holden		State of Maryland / Department of 1-For State Certificate of Registrar		Reg. No. 2008 010
Physicia lical Exami	an/		2. Date o Month Janua	f Death 3. Time of Death
			b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date	of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		217-84-8038 1 XM 2 F 39 Yrs.		Country)
and show any nce.		10a. State 10b. County 10c. City, Town or Location 10an Maryland N/A Balti	on Lmore	10d. Inside City Limit
Marylan 28a-f sh d at onc	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
vith the Mary s 23a or 28a e notified at		5606 Park Heights Avenue 11. Marital Status	21215 s Decedent of Hispanic Origin? (Specify Yes	or No- 14. Race - American Indian, Black,
Should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces? If Ye 1 Yes 2 X No	es, specify Cuban, Mexican, Puerto Rican, etc	
ours afte	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	Yes 2 X No specify: t's Usual Occupation (Give kind of work done	
be filed within 72 horal Hygiene ked other than "u ent, the Medial Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	ost of working life. DO NOT use retired)	Stop Shop & Save
permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other th injury or other traumatic event, the Med	Com	17. Father's Name (First, Middle, Last)	18 Mother's Name (Eirst Mi Charla Ode	ddie Maiden Sumamel SSA HOTNE
uld be f Mental marked c event,	o Be	James Horne, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing		Turbustet, what years and
nd 2 sho alth and m 27 is raumati		Dames normey or 7		21215
ages la nt of He tt: If ite other ti		1 XXurial 2 Cremation 3 Removal from State crematory or oth	ition (Name of cemetery, Pare place) Cemetery 1/19/08	
rmit. P epartme nportan jury or				n-Harris Funeral Hom
ysician	4	23a. Part I. Enter tipe disease, or complications that caused the death. Do not enter the		Road Baltimore, Md 21 ory arrest, shock, or heart Approximate Inter-
Medical aminer	-	failure. List only one cause on each line. Immediate Cause (Final disease a. Narcotic (heroin) intoxic		Between Onset an Death
		or condition resulting in death) Due to (or as a consequence of):		
	iner	Sequentially list conditions, if any, leading to immediate This Enter Underlying Course Due to (or as a consequence of):		
ecuted and transit	Examiner	events resulting in death) Last Due to (or as a consequence of):		
Hospital or Attending Physician: The law requires that the death certificate be executed burns after death. After this certificate has been signed by the attending physician and Funeral Directors. After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transi		X UNPENDED #23,27,28a-f, perME,687	7 3/308 TT	
iificate b ng physi is the bu	n/Me	23b. Was decedent pregnant in the	tal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
leath certificat e attending phy for use as the	Physician/Medical	past 12 months?	her (Specify)	_
hat the d ed by the etached	by Phy	Part II. Other significant conditions contributing to death but not resulting in the u		. Did tobacco use contribute to the cause of death?
quires that en signed uld be deta				Yes 2 No 3 Probably 4 Unknow Was an 24b. Were autopsy findings availa
ie law re ie has be ge 2 sho	Completed			autopsy prior to completion of cause of death?
cian: The certificate ector, page	Be Co	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	Yes 2 No 1 Yes 2 No
Physic rr this c ral dire	ToE	1 ✓ Yes 2 No Inpatient 2 ER/Outpatient		
ending ath. rr: Afte he fune	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation FNd 1/12/2008 FNd 7:44	- 1 Vas 2 V No I smls	scribe how injury occurred
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, stree	et, factory, office building, etc. 28f. Loca	ation (Street and Number or Rural Route Number, C
lospita 4 hours tuneral ely fille		4 Homicide determined (Specify) house 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur		Park Heights Ave. BAltimore,
To the H within 24 To the Fr completel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.		
	ž	29t. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 13, 2008
		30. Name and address of person who completed cause of death (Item 23a)	0.0.IVI.E.	Validary 10, 2000
		Margarita Korell MD. Assistant Medical Examiner 111 P	enn Street, Baltimore, MD 21201	
St Regis	tate trar	31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature	No.	OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 20 13 5,2008 C **JAMES** HUGHES /Medical 4a. Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greneral timore N/A 6. Sex **¾** M 2 □ F If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign
Country) **Funeral** Yrs MARYLAND 71 1936 2 Director Aug 218-32-3334 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 943 ABBOTT COURT 21202 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify: BLACK Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade DISABILITY N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 943 Abbott Ct., Baltimore, Dannielle L. Simpkins/Companion Maryland 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 DCremation 3 ☐ Removal from State METRO CREMATORY 01-17-08 BALTIMORE, MARYALND 4 ☐ Donation 5 ☐ Other (Specify) Marure of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rethicillinnesistant tophy/ocoecus Aureus **Physician** /Medical Due to (or as a consequence of): Examiner reumona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence-of) Examiner Stage The law requires that the death certificate be executed as the burial-transit and Due to (or as a sensequence of) physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached t 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Was a.. autopsy performed? 'as 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate I death? 1 ☐ Yes 1∐ Yes 2⊡ No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🗜 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

7

Baltimore, Maryland 2121

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. D. 90

32. Registrar's Signature

2008

08-00522 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Brenda Karen Hampton State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 18, 2008 Brenda Karen Hampton 1118 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1817 Troutfarm Road Jarrettsville Harford 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY **Funeral** If Under 1 Year If Under 24Hrs. 9. Birthplace (State or 218–46–1527 Months Days Hours Director 60 Feb. 7, 1947 Maine Country) M XXX F Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 XX Jarrettsville MD Harford Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21084 USA 1817 Troutfarm Road Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces Never Married 2 XXMarried Yes white Divorced If Yes, Give Year Widowed Specify: Yes 2xx No specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Complet At Home Homemaker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) Norma Johnson If item 27 is marked Be Merle Elijah Guiou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1817 Troutfarm Road—Jarrettsville, Maryland 21084 Paul Hampton-spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 XX remation 3 Removal from State Jan.20,2008 Forest Hill, Maryland mportant: Other Specify Manature of Funeral Service Licenses Name and Address of Facility
ANS FINERAL CHAPET
OF CREMATION SERVICES Newport Drive Forest Hill,MD 21050 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Mixed drug (oxycodone, paroxetine) & alcohol intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED #£3a,27,28a-f, perME,g877, 3/4/08 TI attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d, Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes Nο 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other4 Inpatient 2 DOA Nursing Home 5 Residence 6 ✓ Other: Scene ER/Outpatient 3 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural Pending 1 Yes 2 Y No the Director: unk Fnd 1/18/2008 Fnd 11:05 am Accident filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Could not be Suicide 1817 Troutfarm Rd. Jarrettsville, MD (Specify) other-scene Homicide

To the Funeral

Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature 2008

Name and address of person who completed cause of death (Item 23a)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

29d. Date signed (Month, Day, Year)

January 19, 2008

State

Registrar

29a. Certifier 1

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January Ĩ8 Δ^{M} Vera E. Hunt 2008 1:45 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1700 Edmondson Avenue Apt. 307 Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday **Funeral** 1 ☐ M 2 💢 F 218-28-9488 74 06/20/1933 Ohio Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ed at 1 XYes 2 No r 28a-f sh Director Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code s 1 and 2 should be filed within 72 hours after death with 18 Health and Mental Hyglene.
tem 27 is marked other than "natural", or items 23a or 2 other traumatic event, the Medical Examiner must be n 1700 Edmondson Avenue U.S.A. Apt. 307 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Black Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Murray's Foods Store Manager 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Crawley Vera Ross 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once. Doretha Hunt / Daughter 3646 Dudley Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 01/23/2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem. Park Ceme. Baltimore, Maryland 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARCINSMA Physician /Medical Due to (or as a consequence of): BREAST Examiner ARCINMA Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed CARCINSMA attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à HYPERTEMION 1 Yes 2 No 3 Probably 4 Unknown Completed peen CONSTIPATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Prumpay come 00056948 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) place Sutte 3H BALLINGE MD 2147 Tamon A MO 300 monon? 32 Registrar's Signature Year) 31. Date filed (Month, Day, State medel 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** William Mahlon Hamilton January 2008 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bal ruane Hos 0 da 05 nKlin If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ★M 2 ☐ F 220-42-9866 61 5, 1946 Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatin event, the Medical Exeminer must be notified at 1 ☐ Yes 2 No Directo Maryland Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2140 Northridge Drive 21015 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or ite 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Quality Assurance Rep. U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William George Hamilton Kathleen (unk) Degel 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 i Linda L. Hamilton (wife) 2140 Northridge Dr., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 1-21-08 Towson, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each fine Immediate Caus (Final **Physician** ardiac disease or condition resulting in death) /Medical ue to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Under in Cause (Disease or injury Examiner The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown signed by the 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 1∐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one examiner? 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Division or Vital Records, P.O. Box 68760,

Registrar

29b. Signature and title of certifier

Date filed (Month, Day,

Year)

se of death (Item 23a) (Type, Print) 9000 Fran

Registrar's Signature

29c. License number

0 00

29d. Date signed (Month, Day, Year)

			1- State of Maryland / Dep. State of Maryland / Dep. Ce	artment of Health and IV	lental Hygie	ene 1. No. 2008 0	1078
	Physici	an	1. Decedent's Name (First, Middle, Last) Ming-Yen Hsu		2. Date of Death Month	Day Year 3. Tim	e of Death
33	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1171
	Sangle San San San San San		Union Memorial Hospital	Baltimore	O. Data of Birth	N/A	
	Funeral Director		5. Social Security Number 6. Sex 1X M 2 F 7. Age (In yrs. last birthday, 85 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) May 21,	Year) 9. Birthplace (Sta Country) Taiwan	ate or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Insid	le City Limits
	a-f sh	ctor	Md. N/A Baltimor	e		1 🗆	Yes 2 □ No
	th with the 23a or 28 ist be no	al Dire	10e. Street and Number 3800 Fenchurch Road	10f. Zip Code 21218	10	g. Citizen of What Country?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian Black, White, etc. Specify: Asian	n,
2-00	72 hou natura lical E	ted	15. Decedent's Education (Specify only highest grade completed) (Give	dent's Usual Occupation	ina 10	6b. Kind of Business/Industry	
121	vithin in the interval in the inter	mple	Elementary/Secondary (0-12) College (1-4or 5+) +4 Teac	kind of work done during most of work DO NOT use retired)		Education	
d 2	ifiled v	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma		
/lan	uld be Mental arked o	To B	Yi Hsu	Man	Chen		
Mari	12 sho h and r is ma trauma		19a. Informant's Name/Relationship (Type. Print) 19b. Mail	ng Address <i>(Street and Number or Rur.</i> O Fenchurch Rd. Ba			
<u>ق</u>	tem 2					Oc. Location - City or Town, Stat	te
E C	Pages nent or ant: If i		1 11 Viburial 2 LiCremation 3 LiBernoval from State 1	Valley Mem. 2-2-0	8	Timonium, Md.	
Baltimore, Maryland 21215-0036	permit. Departr Importa any inju		I / CH	2. Name and Address of Facility Ruck Towson Fun 1050 York Rd. T	owson. M	d. 21204	
	NEW Y		23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. Ast only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	st, Approx Interva Onset	timate I Between and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	epsis		12	-hr
	Examiner		Personation o	& Pyloric chann	cel	20	he
	Si Bo	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause).				
V	execution and al-tran	Examiner	that initiated events resulting in death) Last C				
68760,	flicate be executed physician and is the burial-transi	edical	d				
			IF FEMALE: 23c. If yes, outcome pf pregnancy			A	
O. Box	he death certif the attending shed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day	Year
s, P.O	w requires that the di been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause	e of death?
ords	require	ted b			1 ☐ Ye	s 2√ No 3 Probably	4 □Unknown
Division or Vital Records,	2 38 2	Completed			24a. Was an autopsy perform 1 Yes 2	prior to completion	of cause of
Vita	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Other:	h (Check only one		
o	ਜ਼ ਦੁ ਛ	2	1 Inpatient 2 En/Outpatie	111 3 BOA 4 Nursing Ho	ome 5 Resider 28d. Describe how	nce 6 Other (Specify) w injury occurred	
ion	Attending Pr death. ector: After in the funerant the fune	atior	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	M 1 Yes 2 No			
Divis	al or Atte after de Il Directo	ertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route State)	Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal control of the basis of examination and/or and manner stated.				use(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Ye	-10
			N. J May	AT 2438 946		01/18/20	00
	2		30. Name and address of person who completed cause of death (Item 23a) (Type	1 11	altimore	MD	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	and a			

DHMH 17 Rev 1/2001

			For State	State of	Maryland	•	rtment of F	lealth and I			008	01079
			Registrar 1. Decedent's Name (First, Middle, La	net)			incate of	Dealli	2. Date of Dea	Reg. No."		3. Time of Death
	Physicia	an	Virginia Humphrey						Month January	y 18,	2008	1:40 P.M
	/Medic	al	4a. Facility Name (If not institution, gi		oer)		4b. City. Town. o	r Location of Deatl			ounty of Death	
	Examin	er	Brooke Grove Nurs		,		Sandy S			Mon	tgomery	7
	Funeral				Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birtho	place (State or Foreign
	Director		215-26-0391	1□M 2፟ØF	89	Yrs.	Months Days	Hours Min.	Feb. 10	19	18 Mary	land
P			Usual Residence of Decedent		1							404 Inside Obst limite
arylar	how the	ا ـ	10a. State 10b. County		-	, Town or Lo						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ě.	89-f	Directo	Maryland Montgon	nery	Kei	nsingt						
with ti	S or 2		10e. Street and Number	4-			10f. Zip Code				n of What Cour d State	
ath v	s 23 _c	Funerai	10401 Fawcett St	12. Was Decede	ant Francia III	6 42.1	20895	lispanic Origin? (S			. Race - Americ	
er de	He I	un	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Force	es?	3. 13. V	Yes, specify Cub	an, Mexican, Puerl	o Rican, etc.)	14	Black, White,	
urs at	T, or	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	_	1	I□Yes 2⊠No	Specify:		S	pecify: Whi	te
5 PG 2	ature		15. Decedent's E			16a. Deced	lent's Usual Occup	ation	4./	16b. Kind	of Business/In	ndustry
hin 7	e a	pie	(Specify only highest gi	completed) College (1-4	or 5+)	life. L	NOT use retire	during most of word)	King			
1 M	er th	Completed				Reg	istered				1th Car	e
5	d oth	Be	17. Father's Name (First, Middle, Las	t)					ne (<i>First, Middl</i> e,	Maiden Su	ımame)	
VIO	Men	၉	Benjamin F. Diero					Pearl Ad				
2 sh	of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28e-f show other traumatic avant, the Modical Exeminational Legical Landillad at		19a. Informant's Name/Relationship		. **		-	St., Ker				
Tand	Health		Priscilla Arenas 20a. Method of Disposition	/ Daugne					Date		ation - City or To	
5 8g	Total and a second		1 ☐ Burial 2 ☑ Cremation 3				sition (Name of natory or other pla	n, Inc. Jan	22 2000			
mit. Pages	ntant njury		4 □ Donation 5 □ Other (Spec21. Signature of Funeral Service □		MOHL							
per E	Department of Health a Important: If item 27 is any injury or other training.		21. Signature of Furification Vices	~ ()	M00896	Rot	sert A. Pun	iphrey Fune nsin Ave	ral Home/I	Bethesd cda	la-Chevy	Chase, Inc.
			23a. Part1. Enter the disease, or cor	nplications that cau	used the death						FID 2001	Approximate Interval Between
Di			shock, or heart failure. List only Immediate Cause (Final	one cause on each	_	ter i la	00140				ſ	Onset and Death
	rysician Medical		disease or condition resulting in death)	a	r as a consequ	N. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	MONIA					WEEK
E	xaminer		O and a Mark and a Miles	6								
	-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequ	uence of):						
cuted	nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							= 1	
ou, e be executed	hysician and the burial-transit		resulting in death) cast	Due to (or	r as a consequ	Jence ot):						
16	physic the b	dicai	•	d								
Sertifi	ding	Physician/Med	IF FEMALE:	23c. If yes, outco	ome of pregna	nev				23	d. Date of deliv	/ADV
eath	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 ☐ Fetal nt at time of de	death 3	Ectopic pregnanc Other (specify)	<i>y</i>		20	Month	Day Year
۽ <u>چ</u>	y the	ysi	1 ☐ Yes 2 X No 9 ☐ Unknown	9 Unknow								
, r s that	ned b e deta	by PI	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use	econtribute to t	the cause of death?
w requires	n sig uld bu	pe pe	HOVANCED	SENILE	190	MENT	IA		1□'	Yes 2.0≸	No 3□Proi	bably 4 □Unknown
§ §	s bee	piet	DIABETES N	VELLITUS	Ś				24a. Was		24b. Were auto	opsy findings available ompletion of cause of
The	ite ha	Completed					-			rmed?	death? 1 ☐ Yes	
Cian:	leath. for: After this certificate has been signed by the attending ph the funeral director, page 2 should be detached for use as th	Bec	25. Was case referred to medical examiner?						ath (Check only o	one)		
Physic	this ce at dire	2	1 ☐ Yes 2 X No		oatient 2	ER/Outpatien		er: 4X Nursing H	lome 5 ☐ Resi	dence 6 (□Other (Speci	ify)
ng P	fter t	ë.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury	occurred	
tendi	loath.	cati	2 Accident investigate 3 Suicide 6 Could not	he -				Yes 2 □ No	OSA Legation /	Ctroot and	Number or Dur	ral Route Number,
or At	Direc Direc in by	ertification:	4 Homicide determine	d 289. Place of building	g, etc. (Specif)	me, tarm, str	eet, factory, office		City or To		Vallipel of Hull	ar noute reuniber,
spital	ours ours ours (illed	0	29a. Certifier 1 🛣 Certifying F	hysician: To the b	est of my kno	wledge, death	occurred at the ti	me, date and place	, and due to the	cause(s) a	nd manner as s	stated.
DIVISION OF VIGAL RECOLUS, F.C. BOX 06 to the Hospital or Attending Physician: The law requires that the death certifica	within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	(Check only 2 Medical Execute)	miner: On the bas and manne		tion and/or in	vestigation, in my	pinion, death occu	irred at the time,	date and p	lace, and due t	to the cause(s)
To th	within To th	ž	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	signed (Month,	, Day, Year)
	-		TEHOUS	MD			D33	700	_	JANU	ARY 18	, 2008
1	7		30. Name and address of person who									
+0			Ted Howe, M.D.,		de Sch		ad, Sand	y Spring	, Maryla	nd 20	860	
	Sta Registr		31. Date filed (Month, Day, Year)	22. Rej	metrar's Signa	ture	food					
		- 1	SMILL OF		A CONTRACTOR							

DHMH 17 Rev 1/2001

P.O. Box 68760. Records, Division or Vital To the Hospital or Attending Physician: within 24 hours after death. within 24 hours after death To the Funeral Director:

State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

NORTHWEST

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL

2008

32. Registrar's Signature

5401 OLD COURT ROAD

29c. License number

D54352

MIRCEA TODOR

29d. Date signed (Month, Day, Year)

JANUARI

RANDALISTOWN

2008

State of Maryland / Department of Health and Mental Hygiene $? \; () \; () \; () \; ()$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 11, 2008 9:06 AM M January Melvin E. Imwold /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Heritage Harbor Health & REhab Anne Arundel Annapolis 8. Date of Birth (Month, Day, Yea Apr 27, 1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 1915 92 216-10-1371 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Exerciner must be notified at 1 Yes 2√ No Directo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 Hillcrest Avenue 21234 USA 238 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 24 No or Itams 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ Specify: white If Yes, Give Year or Dates: 3 ☐ Widowed 4 X Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) O carpenter self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental F Samuel Ellworth Imwold ို Mary E. Knipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun Bob Ehrbaker/friend 508 Palisades Blvd Crownsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service I State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 2 Weeks 23a. Part 1. Anter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) (ena **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed Due to (or as a consequence of) Box 68760, by Physician/Medical as the attending IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Fctonic pregnancy ō in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, pe 3 ☐ Probably 4 DUnknown 1 ☐ Yes 2 ☐ No Completed peeu (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s Jas certificate 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 X No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending Injury 1 Natural 5 Pending within 24 hours after death. To tha Funeral Director: A 2 Accident investigation 1 TYes 2 TNo filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and Util f certifi 000 29571 rson who completed cause death (Item 23a) (Type, Print) 2225E Defense Hwy, Crofton, MD 21114 av 3. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMED TIPME OF C. per FH G 95 1/22/08 US
State of Maryland Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 1210 AM MARGARET JORDAN JANUARY 18 Z008 "/Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE CENTER MEDICAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex 9. Birthplace (State or Foreign **Funeral** 212-54-3079 Months 1 ☐ M 2 ☐ F Days Hours Min 60 Director Usual Residence of Decedent purmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at orde. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Be Completed by Funeral Director timore 10f. Zip Code 10g. Citizen of What Co ush12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ပ r Rural Route Number. 19b. Mailing Address (Street and Number lushinaton 20a. Method of Disposition

1 → Burial 2 □ Cremation 3 □ R

4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State WAKunk 2 ☐ Cremation 3 ☐ Removal from State Johns Catholic Cemetery Hollywood, MD 21. Signature of Funeral Service Licenses was and floress of Facility eener Funeral Services nat 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760⊊ Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy **Director**: After this certific in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Yes 2∏ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specity) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 063060 Mus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samt Paul Place Ryan 301 McComack Eurogency Department, 32 Registrar's Signature 31. Date filed (Month, Day, Year) 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 17, per H C*75, 1/22/08 WS
State of Maryland "Department of Health and Mental Hygiene" 1- For State Registrar Amend 20b-c, perFh, G875, 1/25/08 TT Certificate of Death Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Physician Johnson, Sr. Day Year arroll. 2008 1806 16 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner NA BALTIMOR SALIVI AGNES HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**Z**M 2□ F Days 220-20-9776 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 No MT Himore Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USH 21207 Lelox Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social mant. 124ears Malyst 17. Father's Name (First, Middle, Last) Randolph Sonnson 18. Mother's Name (First, Middle, Maiden Surname) Be amper 19a. Informant's Name/Relationship (Type. Print)
Delores P. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3322 Rd. elox Baltimere, 1603 20b. Place of Disposition (Name of Wood Tawii (Panel or or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) re funeral Sis 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or healt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNKROWN /Medical Due to (or as a consequence of): Examiner TAST A Unicipion if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit that the death certificate be executed physician and Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 1☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has funeral director, page 2 s Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: ို 1 🗖 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ö this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 124 hours after death.

The Funeral Director: After the further of the further than 124 hours after 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. the To I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 CATON HUE, BALTIMOREI HAFSA L. KHAN ST. AGNES HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 20 AM Year **Physician** retta 2005 /Medical 4a. Facility Name (If not institution, give street and number, City, Town, or Location of Death 4c. County of Death Examiner Balt Ballmont 'en TMOY dice If Under 1 Year | If Under 24 Hrs. last birthday Social Security Number 6. Sex 7. Age (In yrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🔀 56 371-58-8946 8/26/51 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or home any injury or other trainmant. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County N/A 1y Yes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1015 Stamford Rd 21229 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify.African 1 ☐ Yes 2 🔀 No ٥ م 3 Widowed 4 Divorced American Be Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Service Casework 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Blick Jessie Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Stamford Rd, Balt., Lillian Jackson/mother MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 □Removal from State 1/24/08 Balt. County, MD King Park 22. Name and Address of Facility Hari P. Close F. 21. Signature of Funeral Service Licensee 5126 Belair Rd, Balt., MD 21206-23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nonden 10lese /Medical Due to (or as a consequence of): **Examiner** 0 5 Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Approx Examine The law requires that the death certificate be executed bunal-trar Due to (or as a consequence of): physician at the burial Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an director, page 2 s autopsy performed' 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Year) 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death. filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely fi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) mm 32. Registrar's Signature 31. Date filed (Month, Day, State

Registrar

0846

	Ple	ase Type or	Print in Black In	delible Ink.	Ensure A	II Copies A	Are Leg	ible.	
	For State Registrar	State of	of Maryland / Depa Cer	artment of F rtificate of	lealth and N Death		iene g. No.	08	01085
	1. Decedent's Name (First, Middle, Last) 2. Date of Death								
/sician ledical	John Bandele	Jeffrey-C	Coker		Month January	Day 12, 20	Year 008	12:10P ^M	
aminer	4a. Facility Name (If not institut	ion, give street and πι	ımber)	4b. City, Town, o	4b. City, Town, or Location of Death			ty of Death	
	Shady Grove Ad	ventist Ho	ospital	Rockvil	lle		gomery	У	
eral	5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
ctor	125-66-0509	1 ⊠ M 2□ F	85 Yrs.	, and a supplemental supplement	THE STATE OF THE S	May 16,	1922	Nige	

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be analitical as

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

death certificate be executed attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, ed by the a detached f funeral director, page 2 should To the Hospital or Attending Physician: after death

filled in by the within 24 hours a

Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14411 Traville Garden Circle, #116B 20850 Funeral Nigeria 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Mamed 1 ☐ Yes 2X No Specify. δ 3 ₩Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Executive United Nations 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Rebecca Drucilla Lucas Samuel Jeffrey Coker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bandele Jeffrey-Coker, Son 13428 Scottish Autumn Lane, Darnestown, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State cemetery, crematory or other place.
Columbia Gardens 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2008 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Cemetery Name and Address of Facility
Old Town Funeral Choices
1205 Belle Haven Road, Alexandria, VA 22307 21. Signature of Funeral Service Licensee M00968 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA Minutes CARDIAC Due to (or as a consequence of): FAILURE RESPIRATORY Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine NEGATIVE Due to (or as a consequence of): FAILURE Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 1□ Yes 2XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ို 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident injury 1 Yes 2 No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife D0064478 JANUARY 12 2008 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

State Registrar FISE HATSION

31. Date filed (Month, Day, Year)

JAN 22

MEHARI

MID

32. Registrar's Signature

9901 MEDICAL CENTER DRIVE ROCKVILLE

O M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:00 p^M 14 2008 JAMISON January DOROTHY W. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE BON SECOUR HOSPITAL-ER. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Dec 22 19: 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2XXF NORTH CAROLINA 84 Dec. 1923 Director 225-28-4243 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, he Medical Examiner must be notifiled at 1 X Yes 2 □ No Director MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2026 RIDGEHILL AVENUE U.S.A. 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK ş 3 XWidowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " any injury or other traumatic event, the Men Elementary/Secondary (0-12) College (1-4or 5+) BAKERY/NURSE AIDE FOOD & HEALTH 5th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAKE PERKINS GEORGETTE PERKINS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Blessing Jamison/DAughter 2026 Ridgehill Ave. Baltimore, Md., 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dopation 5 □ Other (Specify) GARRISON FOREST 01-24-08 OWINGS MILLS, MARYLAND ure of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Desbara Chiloun Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hours /Medical Due to (or as a consequence of) Nsive Cardiovascular Disease **Examiner** Hyperte Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conséquence of): Examiner burial-trar Due to (or as a consequence of): Physician/Medical the the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? <u></u> 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2X ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No

be executed Box 68760, physician attending p for use as signed by the a P.O. Records, cate has been si page 2 should t certificate Division or Vital After this 4 hours after death.

4 hours after death.

5 uneral Director: A ely filled in by the fu death. of the Hc.
within 24 hours.
To the Funeral Directory filler

Baltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Signature and title of or

30. 11 Imm and address of person who completed cause of death (Item 23a) (Type, Print)

3512 New and 21218 Jan 15,2008

State Registrar 31. Date filed (Month, Day, Year)

SchWARTZ

6 Could not be determined

3 Suicide

4 Homicide

Jau

32. Registrar's Signature

MA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year 2008 18:35 p 20 JANET D. JOHNSON January 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, HARFORD CO 3011 BLUEHOUSE ROAD STREET If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number Months Days Hours Min 1 □ M 2 XF 50 Jan 9 1958 MARYLAND 212-70-5184 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 TYes 2 XNo HARFORD CO STREET MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3011 BLUEHOUSE RD. U.S.A. 21154 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXio Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MERCEDES BENZ 12th grade SUPERVISOR 2yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EFFIE V. DORMAN JAMES R. DORMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Johnson/Husband 3011 Bluehouse Rd., Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-22-08 METRO CREMATORY BALTIMORE, MARYLAND 21. Signature of Funeral Service License 22 Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, 0 321 S. PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate

Physician /Medical Examiner

and

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

"natural", or

or other traumatic event, the Medical

Department of Health ar Important: If Item 27 is any Injury or other traconce.

is marked other than

Director

Funeral

δ

Completed

Be

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed

To the Hospitai within 24 hours a

Division or Vital Records, P.O. Box 68760,

ours after death. neral Director: A rilled in by the fu Cartifica

	a a
	be Completed by Physician/Medical Exa
í	20
Í	듬
3	ē
2	15
5	<u>.</u> <u>.</u> <u>.</u> <u>.</u>
5	2
5	%
	<u>C</u>
3	>
3	1 = 7
3	l e
	1 0
5	ם
3	10
-	0
ź	m
Š	0
g	ion: To
	1 5
-	1 :Ξ

Immediate Cause (Final disease or condition resulting in death)	a Pancreat	ic Carc	whoma		3 40ars
resulting in death)	Due to (or as a consequ	ence of):			
Sequentially list conditions, late cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	ence of):			
resulting in death) Last	Due to (or as a consequent)	ence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnal 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3 ☐ Ectopic p			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resu	lting in the underlying o	ause given in Part I.		use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 【QUnknow
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?				eath (Check only one)	
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 ☐ DC	OA Other: 4 Nursing	Home 54 Residence	6 ☐Other (Specify)
27. Manper of Death 1 DNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
3 Suicide 6 Could not b 4 Homicide determined		me, farm, street, factor	y, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the best of my know miner: On the basis of examinat and manner stated.	vledge, death occurred ion and/or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the cause(s curred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
29h Signature and title of certifier		29	c. License number	29d. Da	ate signed (Month, Dav, Year)

DHMH 17 Rev 1/2001

State

Registrar

uarles

31. Date filed (Month, Day,

Year)

2008

completed cause of death (Item 23a) (Type, Print)

5601 Lock Baven

32 Registrar's Signature

Jan 22 2008

Baltimore MD 21239

Willie Clayton Joyner
08-00333 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

INK UNK	State of Maryland / Dep 1- For State Ce Registrar	ertificate of Death	and Mental Hy	/giene Reg.	No. O O	
Physician Medical Examine	Decedent's Name (First, Middle,Last)			2. Date of Death Month D January 12,	200	3 Time of Death 1352 hrs
"`\.	4a. Facility Name (if not institution, give street and number)	4b. City, Tow	n, or Location of Death		4c. County of Deat	
_	Johns Hopkins Hospital	Baltimo				
Funeral Director	5. Social Security Number 217–27–6105 6. Sex 7. Age (In yrs. 18	. last birthday) If Under 1 Months Yrs.	Year If Under 24Hrs Days Hours Min.	8. Date of Birth	(MM/DD/YYYY) 9. Bi Forei Co	thplace (State or gn MARYLAND puntry)
ny .	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Location				10d. Inside City Limits
rd F Fee	MD N/A	BALTIMORE	CITY			1 X Yes 2 No
tith the Maryland 23a or 28a-f show any notified at once. al Director	10e. Street and Number	10f. Zip Co		10g	. Citizen of What Cou	ntry?
th the 7 23a or notified					USA	
or items		If Yes, specify C	of Hispanic Origin? (Sp Suban, Mexican, Puerto No specify:		White, etc.	ican Indian, Black,
ours aft Rtural" Camine	l or Dates:	16a. Decedent's Usual Oc	cupation (Give kind of v		16b. Kind of Business	/Industry
5-0036 let within 72 hours after lygiene. other than "natural", the Medical Examiner.	Elementary/Secondary (0-12) College (1-4 or 5+) 9TH	LABOR	g life. DO NOT use reti ER	red)	LABOREF	!
마 글 뜻 글 목 (THOMAS EARL JOYNER			DELPHAN	E CLAYTON	01015
Oggin	19a. Informant's Name/Relationship (Type, Print) TONYA D. CLAYTON / MOTHER	19b. Mailing Address (•	
ore, MEss 1 and 2 s of Health at If item 27	20a. Method of Disposition 20b. 1 X Burial 2 Cremation 3 Removal from State	Place of Disposition (Name crematory or other place)	of cemetery,	Date	20c. Location - City o	r Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite	4 Donation 5 Other Specify:	IT. CÁRMEL CÉM	ETERY 01,	/25/08	BALTIMORE	, MD
Baltimo permit. Page Department o Important: injury or otd	21. Signature of Funeral Service Licensee		ERTY HEIGH	rs ave, :		21207 MD
Physician / Medical	2/a Part 1. Enter de disease, or complications that caused be deal failure. List only one cause on each line.		lying, such as cardiac c	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
raminer	nundiate Cause (Final disease condition resulting in death) a. Stab Wound of Chest Due to (or as a consequence					
5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	e of):				
ted Insit	cause. Enter Underlying Cause (Disease or injury that initiated					
executed an and al - transit	events resulting in death) Last Due to (or as a consequence d.	or):				
migi g	UNPENDED AMENDED					
		egnancy 2 Fetal death	3 Ectopic pregna	ancy	23d. Date of delive	ry Day Year
). Box 6876, the death certificate by the attending phy iched for use as the Driveinian/M.	past 12 months? 4 Pregnant at time of	_)			8
or the de by the ached f		t resulting in the underlying ca	use given in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
ords, P.O. w requires that the speen signed by should be detact.				1 Yes	2 🗸 No 3 Pr	obably 4 Unknown
Records, The law requires froate has been sig				24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
tal Rec				1 ✓ Yes 2		
Vital I hysician: this certifi I director,		✓ ER/Outpatient 3 DOA	Place of Death (Check		Residence 6 Oth	er;
ing Ph After t funeral	27 Manner of Death 29a Date of Injury	4040 has	c. Injury at Work?	28d. Describe hi Subject stab	ow injury occurred	
Division o Division o Spital or Attending tours after death. neral Director: After filled in by the fune	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Convenie	t home, farm, street, factory, o	ffice building, etc.	or Town, Sta		Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the						
F × F ×	<u>^</u>	1	icense number		29d. Date signed (M	
	Noma Mine Ji, MID.		D.C.M.E. ———————		January 13, 20	J8
	Name and address of person who completed cause of death (Its Donna M. Vincenti, MD Assistant Medical Ex-		reet, Baltimore, M	1D 21201		
Stat Registra	# # # # # # # # # # # # # # # # # # #	ature				· · · · · · · · · · · · · · · · · · ·

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 19, 2008 January 8:00 A. M Ivar Krogh Jensen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Brighton Gardens Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 21, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1⊠M 2∏ F 042-12-9221 92 Oct. 1915 Norway Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 V No Director Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20852 5550 Tuckerman Lane #251 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 No
If Yes, Give
Year or Dates: 1942-45 1 Never Married 2 Married 1 ☐ Yes 21 No Specify:White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor of Education Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dagny Fredricksen Johan Jensen 2 19a. Informant's Name/Relationship (Type. Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Jense Taubman / Daughter|4743 Bradley Blvd., #407, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Jan. 27, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens, 22. Name and Address of Facility Spert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, M00896 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic Heart Disease /Medical Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions, Que to for as a nonsequence of Examiner it any, teaching to immedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Osteoarthritis burial-tran Due to (or as a consequence of): Physician/Medical Dementia the IF FEMALE: asn. 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy perform 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2N No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner requires that the death certificate be executed and physician certificate this After t Hospital or Attending ours after death neral Director; / filled in by the f death 24 hours a Funeral I certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 2 and manner stated. 29c. License number 29b. Signature and tit 29d. Date signed (Month, Day, Year) January 21, 2008 D53691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajay Reddy, M.D., 6320 Democracy Blvd., Bethesda, Maryland 20817 32. Registrar's Signature 31. Date filed (Month, Day, Yea State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

			Please Type or	Print in Blac	ck Indelible	Ink. E	nsure Al	Copies	Are Leg	ible.	
			For	f Maryland /	•			ental Hyg	iene	222	0.1.0.0.0
			State Registrar		Certificate	of Dea	ath	2. Date of Deat	eg. No.	108	3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last) Virginia John	son				Month	Day	Year 2008	15:47PM
- E.	/Medic		4a. Facility Name (If not institution, give street and no		4b. City, T	own, or Loca	ation of Death	01		ty of Death	10,41.
	Examin	er	GOOD SAMARITAN		TAL BA	LTIN	MORE				
7	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months		Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day 12/31/	Year)	9. Birthp	olace (State or Foreign
	Director	j,	282-34-7649	69	Yrs.			12/31/	1938		PA
	yland iow at		10a. State 10b. County	10c. City, To	wn or Location					1	10d. Inside City Limits
	a-f sh	ctor	MD Baltimore		'1'0	wson					1 XXYes 2 No
	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show diral Examiner must be notifiled at	Director	10e. Street and Number 107-2B Kenilworth Par	r Drive	10f. Zip (Code 2020	04	1	0g. Citizen o US		ntry?
	eath w	Funeral		edent Ever in U.S.	13 Was Decede			cify Yes or No-		ace - Americ	can Indian.
	r Item	표	Armed F 1 □ Never Married 2 □ Married 1 □ Yes	orces? 2 🔀 No	13. Was Decede			Rican, etc.)		ack, White,	
936	ral", o	b	3X Widowed 4 ☐ Divorced If Yes, G Year or I	ve Dates:	1 ☐ Yes 2	No Sp	pecify:		Spec	ify: Wh:	ite
5-0	72 hc "natu	etec	15. Decedent's Education (Specify only highest grade completed		Sa. Decedent's Usual (Give kind of work life. DO NOT use	Occupation k done durin	n ng most of worki	ng	16b. Kind of	Business/In	ndustry
21215-0036	filed within Hygiene.	Completed	Elementary/Secondary (0-12) College	1-4or 5+)	Waitre				Food	Indu	stry
	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)			18.		(First, Middle,		ame)	
ylar		T0 E	Samuel Fattori				Kathr		urich		
Maryland	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type. Print) Tina Newcome / Daughte		9b. Mailing Address 239 E. P	•			· ·	n, State, Zij	p Code)
	ges 1 and 2 t of Health If Item 27 or other tra		20a. Method of Disposition	20b. Place	of Disposition (Nam	e of	<u> </u>	Date	20c. Location	n - City or T	own, State
JOI.	Pages ent of nt: If II		Marial 2 ☐ Cremation 3 Marenoval from 4 ☐ Donation 5 ☐ Other (Specify)		etery, crematory or ot in Heights		tery 1/	19/2008	Uni	ontow	n, PA
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		21. Signature of Euneral Service Licensee	1 11	22. Name and	d Address of	f Facility	Funera	1 Home	Tnc	
8	8 3 E E 8	0 11	Dorsta W. Ma		1501 E	ast F	<u>'ort Ave</u>	nue, ba	<u>ltimor</u>	e, MD	
ı		ģ.,	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.							Approximate Interval Between Onset and Death
	Physician /Medical			RCINOMA		14 W	117H ME	DIASTIN	AL MET	ASTASIS	
	Examiner			(or as a consequence	e or).						
	MANA	ner	Signature of the state of the s	(or as a consequenc	ce ot):						
V	ecutec and I-transi	Examine	that initiated events	/	6)-						
68760,	ria e		Due to	(or as a consequenc	e or).						
687	ficate physis the	edic	d								
Box (leath certificate be attending physicii I for use as the bu	M/M		utcome pf pregnancy birth 2 Fetal dea		oanonau			23d.	Date of deliv	very
	The law requires that the death ate has been signed by the atten bage 2 should be detached for u	Physician/Medical	In the past 12 months? 1 ☐ Yes 2 🛣 No 4 ☐ Pre	mant at time of death						Month	Day Year
P.0	res that the de signed by the a be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to		n in the underlying of	ause given in	n Part I	23e Did to	hacco use c	ontribute to	the cause of death?
ds,	signe signe d be c	l by	HODGKINS LYMPHO		g ar the underlying et	adda given n	Trait is	1 🗆 ነ			
Records,	w require been sig	Completed	CEREBROVASCULAR		†			24a. Was	an 24	b. Were aut	topsy findings available
	sician: The law s certificate has t irector, page 2 s	ошр	CEREBROTTION CAR	ACCEPTION	1				sy rmed? 2₩ No	prior to co death? 1 ☐ Yes	ompletion of cause of 2 ☐ No
ita	fan: rtifica stor, p	Be C	25. Was case referred to medical examiner?			26	6. Place of Deat	h (Check only o	4-	100	20,10
۲ \	hysic this ce al direc	2	1 Yes 2 No Hospital:		Outpatient 3 DO			me 5 Resid			eify)
Division or Vital	Attending Physician: The releath. ector: After this certificate he by the faneral director, page	ion:	1 ☑ Natural 5 ☐ Pending (Mo	e of Injury onth, Day Year)	b. Time of 2 Injury M	8c. Injury at Work?	3 2 □ No	28d. Describe h	low injury occ	curred	
isi	a er death Birector: /	ficat	3 Suicide 6 Could not be 28e. Pla	ce of injury - At home,			7 2 2 1 1 1			mber or Ru	ral Route Number,
in	sa er al Dire	Certification:	4 ☐ Homicide determined bui	ding, etc. (Specify)				City or Tov	n, State)		
	Hospital or 24 hours a e Funeral Dir tely filled in		29a. Certifier (Check only 2 Medical Examiner: On the	basis of examination							
	the the mple	Medical	one) and ma 29b. Signature and title of certifier	nner stated.	290	. License nu	umber		29d. Date sig	ned (Month	n, Day, Year)
	or Vitt		DEMOS MD			RES	000				2008
	1)		30. Name and add ss of erson who completed ca								
	7	1		DSAMAR		SPITE	AL, BA	HOMITLE	RE M	D 2	1239
	Sta	ate	31. Date filed (Month, Day, Year) 32.	Registrar's Signature	A SOURCE !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 03AM Jan /Medical Town, or Location of Death 4c. County of Death Examiner ns ferry Holli more If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 1 M 2 □ F 3012 Yrs. 10/17/1932 MD**Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla addrenent of Health and Mental Hygiener addressing them 23a or 28a-f show fortant: If flem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at Himore 1 Mes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2□ Yes, Give ear or Dates: 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ath aborer 17. Father's Name (First, Middle, Last) ner's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Ty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 bepartment of Health a mportant: if item 27 is we. Tzalto. 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) wings Mills, and 21. Signatur of Funeral Strvice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** days /Medical Due to (or as onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9□Unknown 9 ☐ Unknown Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ pe The law requires 1 □ Yes 2 No 3 Probably Ø Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? Yes 22 No certificate 1☐ Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home S Residence 6 ☐ Other (Specify) 21X No 1 Yes P 1 Inpatient 2 ER/Outpatient 3 DQA within 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 12Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 ☐ Homicide 29a. Certifier tScrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Datę signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 22

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10:35 P^M 2008 January 15, Adaire Jeannette King /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery | Months | Days | Hours | Min. | August 23, 1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖾 F 88 Maryland Director 069-14-9745 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eatth and Mental Hygiene.
n 27 Is marked other than "natural", or items 23a or 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Kensington 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3618 Littledale Road 20895 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No þ Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) event, the Owner/Operator Antiques 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ Albert Barber Zola J. Resto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra. Christine Spates / Daughter 19226 Dimona Drive, Brookeville, Maryland 20833 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Jan. 21, 2008 Bethesda, Maryland Montgomery Crematorium 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Fungral Service Licensee M01473 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) heumonia. **Physician** /Medical Due to (or as a consequence of): **Examiner** In Wenza Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of) Due to (or as a consequence of): Hospic Stenoss Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Ö 9 Unknown signed by t ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ a widers. CENEMO Vaecular 2 No 3 Probably 4 Unknown 1 Yes Completed Juleyian. raut num 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No 1☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 npatient 2 ER/Outpatient 3 DOA Division or this Phospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 🗅 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number and manner stated. 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO elaelda. 2811. 32. Pojiștrar's Signature 31. Date filed (Month, Day) Year. State Registrar

DHMH 17 Rev 1/2001

ė

ADAIR

Registrar

State

6701 N. Charles St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

JAN 2 2

m D

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 26 per verb 6 875 01/22/08dhb

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Danuary 17, Grace Elizabeth Krieg 2008 4:28 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth Month, Day Yes 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 5. Social Security Number ^{Year)}1915 1 □ M 2 X F 92 Yrs 216-09-0161 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Lutherville MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1312 Warwick Drive 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. White Specify 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Pecora Agatina Reina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Titus (grand-daughter) 1312 Warwick Drive, Lutherville, MD 21093 Katrina 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐ RemovaL from State 01/21/2008 Baltimore, MD. 5 Other (Spectly) Holy Redeemer Cem. Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 1050 York Road, Towson, Maryland

Physician /Medical Examiner

Department of Important: If its any Injury or o once.

Physician

/Medical

Examiner

Funeral

Director

iral", or Items 23a or 28a-f show Examiner must be notified at

"natural",

al Hygiene.

Pages 1 and 2 s nent of Health an item 27 i

other traumatic event, the Medical

Director

Funeral

Completed by

å

2

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trar

use

law requires that the death certificate be executed

or Attending Physician:

ours after death.
neral Director: /

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

24 hours a e Funeral I Hospital

within 2.

2

Division or Vital Records, P.O. Box 68760,

	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.			ic or respiratory arrest,		Interval Between Onset and Death
	Immediate Cause (Final disease or condition	a Acure	Leuk	einia			untus
	resulting in death)	Due to (or as a conseq	uence of):				
iner	Sequentially list conditions, if any, leading to immediate	bDue to (or as a conseq	uence of):			83	
cal Exam	Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):				
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c 9 □ Unknown	al death 3 ☐ Ectopic	pregnancy (specify)		23d. Date of de Month	elivery Day Year
ed by Ph	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	g cause given in Part I.		. 4	to the cause of death?
Completed					24a. Was an autopsy performed?	prior to death?	autopsy findings available completion of cause of s 2 No
Be (25. Was case referred to medical			26. Place of De	eath (Check only one)		
TO E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 Other (Sp.	ecify) Hospice
ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, farm, street, fact	tory, office	28f. Location (Street a City or Town, Sta	and Number or F te)	Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

N. Charles St Towson

DHMH 17 Rev 1/2001

Registrar

6701

and manner stated

ND

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WES

State of Maryland / Department of Health and Mental Hygien® 0.00

	1	\cap	0	C
U	ı	U	3	-

				State of Ma	il ylallu / L	Certific	ate of	neaith and iv Death		Reg. No.	8 0109	J
			1. Decedent's Name (First, Middle, La	st)					2. Date of Dee	eth	3. Time of Death	1
	Physici		HELEN				KA	PLAN	Month Janyar	1.0	ear 208 5:15	pn
The same of the sa	/Medi Examir		4a Fecility Name (If not institution, giv	e street end number)				4b. City, Town, or Lo	cation of Death			-
A. I			NORTH OAKS HEAL	TH CENTER				PIKESVIL	LE	BALTIM	IORE	
	Funeral		5. Social Security Number 6. S		(In yrs. last bir	thday) If Ur Mont	nder 1 Year ths Days		8. Date of Birth (Month, Day 03/25)	y, Year) 9	Birthplace (State or Fore Country)	∍ign
	Director		216-30-1166	LM 2101 F	80	Yrs.			03/25	/1927	MD	
	pur *		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, Town	n or Location					10d. Inside City Lim	nits
	Aaryli sho	5	MD BALTIM	ODE		ESVILL	_				1 □ Yes 2 🗖	
	the N	ec ec	10e. Street end Number	UKE	PIN		Zip Code			10g. Citizen of Wha	at Country?	
	with year	<u>a</u>	725 MOUNT WILSON	LANE #61	5			1208			USA	
	Jeath Tre 2:	era	11. Marital Status	12. Was Decedent B		13. Was De			ecity Yes or No-	14. Race	American Indian,	-
20	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Examiner must be notified at once.	by Funeral Director	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			specify Cub s 20 No	lispanic Origin? (Sp en, Mexican, Puerto Specify:	Rican, etc.)	Black, Specify:	White, etc. WHITE	
21215-0020	72 hour	To Be Completed t	15. Decedent's Ed (Specify only highest gre	ducation	16a.	Decedent's U	Jsual Occup f work done	pation during most of work d)	ing	16b. Kind of Busin	ness/Industry	_
121	vithin Pan Pan	E E	Elementary/Secondary (0-12)	College (1-4or 5 5+	+)			UNSELOR		EDUC <i>P</i>	TION	
d 2	Hygie ther t	ပ္ပ	17. Father's Name (First, Middle, Last)	_		GUIDAN	CE CO		e (First Middle	Maiden Sumame)	TION	-
an	ad be	Be	LOUIS		νΛD	LAN		REBECC		,	CAPLAN	
<u></u>	shoul od Me merk	۲	19a. Informant's Name/Relationship (Type, Print)	-		ress (Street	and Number or Run		r, City or Town, St		
Maryland	od 2 stranger tranger	j	DEBORAH SANDLER					OOD ROAD,			21234	
ē,	f Hearlitem	1	20a. Method of Disposition		20b. Place of cemeter				Date	20c. Location - Ci	ty or Town, State	
Ë	Page ient o nt: if		1 ABurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific			H TFIL			/18/08	BALTIMO	RE, MD	
Baltimore,	permit. Departmimporta	1	21. Signature of Funeral Service Licer	nsee		22. Name	e and Addre				ROS., INC.	
Ω	89 5 8		Kouto /	7	\supset	890	0 REI				LE, MD 2120	8
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do r	not enter the	mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between	
	Physician										Onset and Death	1
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. (G	rkin.	son's						
		je je	,		Due to (or as a	consequence	of):					
	nsi 🔨 ris	edical Examiner	Commence the first secretary	b	Due to (or as a	onceduence.	of):					
oʻ	tificete be executed g physician en es the buriel-transit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	'	Due to (or as a t	consequence	orj.					
68760,	ite be iysicii	cal	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as a c	consequence	of):					
39		Med	resulting in death) Last									
P.O. Box	ath ce ttendi	lan		d					-			
<u>.</u>	e de the e	/slc	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the underlyi	ng cause giv	en in Part I.	23b. Did 1	obacco use contr	ibute to the cause of de	ath?
<u>ď</u>	v requires that the death cer been signed by the ettendir should be deteched for use	by Physician/M	Dementia						10	Yes 2□No 3	☐ Probably 4☐ Unkr	iown
ds,	signe d be								24a Was	an eutopsy	24b. Were autopsy finding	as
Š	r requ	Completed	Hypertensia	21						med?	available prior to completion of cause	•
Re	has bas	립									of death?	
<u></u>	icete	ပ္	Of W						101		1 ☐ Yes 2 ☐ No	
₹	sicla: certifi irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ № 0	Hospital: 1 ☐ Inpatie	a EB/O	tpatient 3	Oth	26. Place of Deat ner: 4 4 Mursing Ho			(Faccity)	- 1 - 11
o o	Phy or this eral d	5	27. Menner of Death	28a. Date of Injur (Month, Dey		Time of	28c. Inju	ry at		now injury occurred		
<u>0</u>	ath. :: Afte	읉	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Year) I	njury M		nk? Yes 2 □ No				
Division of Vital Records,	r Atterder	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		iry - At home, fa	rm, street, fac	ctory, office		28f. Location (5 City or Tox		or Rural Route Number,	
Ω	rel DI	S					rot tracol					
	To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical		ysicfan: To the best on niner: On the basis of and manner ste	examination en							
_	Vithir To the	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signed (
			* Karen L	Bulit	(, M, P.		DO	105867	6	Januar,	1 14, 2008	
	10		30. Name end address of person who	completed cause of de	eath (Item 23e)	(Type, Print)				C>		_
			Karen L. Bobit.	M,D, M	ODO C	ld con	17+ K	000, 5417	C 201	DG/TI MON	WD 5/20	5
	Sta Registr		31. Dete filed (Month, Day Year)	20002. Hegistra	a organization	September 1					MD 2/20	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 20 BORIS KUCHEVSKY 2008 12:10A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 343 TIMBER GROVE ROAD OWINGS MILLS BALTIMORE Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months 1271271958 49 219-43-6725 Director RUSSIA Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nent of Haalth and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23e or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23e or 28a-f shov must be notified at 1 ☐ Yes 2 No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 343 TIMBER GROVE ROAD 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ WHITE Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life RESEARCHIED)

DEVELOPMENT
ENGINEER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) ADELL PLASTICS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be RUVEN KUCHEVSKY FAYA APELEVICH 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 343 TIMBER GROVE ROAD, OWINGS MILLS, MD OLGA KUCHEVSKY / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH JACOB CONG. 01/20/2008 FINKSBURG, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 011. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Adenicarcin **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Due to (or as a consequence of) physician Physician/Medical the ast IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? res 2 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a To the Funeral L

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAIN

29d. Date signed (Month, Day, Year)

and manner stated.

25

32. Registrar's Signature

A Control of Breed

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUÄRY 2008 Raiston ROSSIS 6:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE MILFORD MANOR NURSING HOME BALTIMORE 8. Date of Birth (Month, Day, Year) 6/16/1915 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday Sirthpu Country OH **Funeral** Months Days Hours Min. 1 X M 2 □ F 92 569-07-8635 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Exaπlner must be notifled at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 1450 BEDFORD AVE., APT. 603 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 N Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE þ 3 X Widowed 4 □ Divorced "natural" Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the HYDRAULICS ENGINEER ENGINEERING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill Health and Mental H tem 27 is marked ott Be KOSSIS DAVID GRACE WEISSBERGER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHANI SZAJOWITZ / GRANDDAUGHTER 3316 SHELBURNE ROAD BALTIMORE, MD Pages 1 ar nent of Heal nt: If Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State Department of Important: If any injury or once. BETH ISRAEL CONG. 01/16/2008 | LOS ANGELES, CA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIO- Pulmo NAR MMEDIATE AFREST /Medical Due to (or as a con equence of): Examiner ARTOR Collowhen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and substransit death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, signe be c Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: or Attending Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) ddress / pelson who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Julian

31. Date filed (Month, Day

835

MO

32. Registrar's Signature

A. Land Library

AKO BOULT

Year)

KING, Elaskem

				se Type or Prin State of Ma					-	•	е.	
		_	For State Registrar Amend 19b,p	erFh,g875, 1/2					F	Reg. No. 201	18	0 0 9 8
	Physicia /Medic		1. Decedent's Name (First, Middle, Elaine	Marie	King				2. Date of Dea Month	Day Ye	ar 7	3. Time of Death 352 A M
	Examin	er	4a. Facility Name (If not institution, Doctor's Commun		1		4b. City, Town, or Lanha	Location of Death		4c. County of Prince		rge's
33. 86.	Funeral Director		095-26-8388	6. Sex 7. Age 1 □ M 2 1 F	e (In yrs. last bii 74	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 01/26/1	Year) 9. 1933	Birthplac Country	e (State or Foreign) NY
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County NY Ki	ings	10c. City, Tow	n or Lo	cation Brook	clyn			10d	. Inside City Limits 1 □XYes 2 □ No
	with the 3a or 28a st be noti	I Director	10e. Street and Number 1874 Bedford	Avenue	t		10f. Zip Code 11225	5		10g. Citizen of Wha		?
30	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ▼ Divorced	12. Was Decedent E Armed Forces? at I yes 25 N If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐★No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Black, '	White, etc	
212-0030	hin 72 hou e. In "natura Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed)		(Give life. i		ation during most of work d)	sing	16b. Kind of Busin		
N	e filed wit al Hygiene other tha vent, the		12 17. Father's Name (First, Middle, L	5+	,	Ed	ucator	18 Mother's Nam	e (First, Middle,	NYC Boar Maiden Surname)	d of	Education
land	ild be fi lental H rked ot ilc evel	To Be	Albert Edward							n Harris		
_	and 2 should be fealth and Mental In 27 is marked of ter traumatic eve		19a. Informant's Name/Relationshi		191	o. Mailir 1623	ng Address (Street Reiker Ricker	and Number or Rui Drive, La	rai Route Numbe rgo, MD	er, City or Town, Sta 20774	ate, Zip C	ode)
saitimore,	Pages 1 a ent of Hea nt: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		cemete	ery, cřel	osition (Name of matory or other place Cremato	ce)	Date /2008	20c. Location - Cit Bronx, N	-	n, State
pair	permit. Pages 1 Department of H Important: If ite any Injury or of once.	ļ	21. Signature of Funeral Service L		M		2. Name and Addres Last. 501 East.	. Stevens	Funera nue, Ba	l Home In ltimore,	c. MD 2	1230
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, isaumy to immediate cause. Enter Underlying Cause Obsease or injury	a. Due to (or as	ne. LHYTA a consequence	of): CE	NA	ng, such as cardiac		rest,	A In	Approximate riterval Between Inset and Death
	eath certificate be executed attending physician and for use as the burial-transit	ledical Examine	resulting in death) Last	c	a consequence	of):						
C. Box	0 0	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deat		⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date of Month		r yay Year
ras, P	The law requires that the dite has been signed by the sage 2 should be detached	by	Part II. Other significant conditio		ut not resulting	in the u	nderlying cause giv	ven in Part I.		obacco use contrib Yes 2 □ No 3		
Vital Records,	The lar	Completed							1□ Yes	ormed? de: 2 No 1	ath?	sy findings available pletion of cause of
7	ysiciar iis certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 PER/O	utpatie	nt 3 DOA Oth	26. Place of Dea ner: 4 ☐ Nursing H		one dence 6 □Other	(Specify)	
ouo	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investig.	28a. Date of Inju (Month, Date of Inju-	ay Year) 28b.	Time of Injury	Wo	ry at rk? ∣Yes 2 □ No	28d. Describe	how injury occurred		
DIVISION OF	il or Atten after deat Director: d in by the	Certification:	3 Suicide 6 Could n 4 Homicide determi	-116 -	ury - At home, f ic. <i>(Specify)</i>	arm, st	reet, factory, office		28f. Location (: City or To	Street and Number vn, State)	or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; it	edical C	(Check only 2 Medical I	g Physician: To the best Examiner: On the basis o and manner st	of examination a	nd/or ir	rvestigation, in my	opinion, death occu	irred at the time.	date and place, an	d due to	the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	$\gamma \wedge h \wedge n$			29c. Licens	se number		29d. Date signed	Month, D	ay, Year)
1	6	Į.	30. Name and address of person v	who completed cause of c	ieath (Item 23a)	(Type,	Print)	60545	0	.1181	しな	
	10		AIFIL MING(31. Date filed (Month, Day, Year)) MD. 811	8 Good	1 h	uck Rd	· , Lax	iam,	MD. 20	706	
	Sta Registi		JAN 2 2	and manner st minimum of the manner st min	ar s signature	of the same	346					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AN /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Examiner EN BURNIE HEALTH & REHAB CENTER ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 X M 2 ☐ F Age (In yrs. last birthday)
Yrs. Social Security Number **Funeral** 220-03-628 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARULAND 10g. Citizen of What Country? 10e. Street and Number USA Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 🔼 No Baltimore, Maryland 21215-0036 BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages ' Department of H Important: If It any Injury or o 1 ☑Buria 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Si ature of Fu eral Service Licensee IR. FUNERAL HOME BALTO, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** north disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed the attending physician and the for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 100 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ 16 26. Place of Death (Check only one) Be Other: 4 Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient P 27. Mann Toeath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 letural 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WI 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) und 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Decompose Deco				1 - For State Registrar	State	of Marylan		artment of tificate of		and Me	ental Hy	giene Reg. No.	008	0	00			
Comparison of Countries Control of Countr		Physici	an	1. Decedent's Name (First, Middle, La		_				- :			Year	3. Time of	Death			
ENVENTY HEALTHAARE CENTER Control Control											18, 2008 3:50 A							
Second Second Foreign 2.5 pear 3.5 pea		Examin	er	,		,												
The content of the		Funeral					last birthday)	if Under 1 Yea	r If Under 2	24 Hrs. 8	B. Date of Bi	rth	9. Birth	place (State o	r Foreign			
Total State Total County Total State Total County Total				215-26-0823	1 □ M 2 X F	7.8	Yrs.	Months Days	Hours	Min.	7/16/	1929						
The state of the s		and w				10c. Cit	v. Town or Lo	cation						10d. Inside Cit	tv Limits			
The state of the s		Manyl.	o		LL													
The state of the s		r 28a	irec	10e. Street and Number				10f. Zip Code				10g. Citizer	of What Cou	intry?				
The state of the s		th with	ai D	2110 EBBVALE	RD.			211	02			USA						
The state of the s		r dea	uner		Armed F	orces?	.S. 13.	Was Decedent of f Yes, specify Cu	Hispanic Orig ban, Mexican	gin? (Spec , Puerto R	ify Yes or Ni ican, etc.)	o- 14.						
The state of the s	36	rs afte			1 DYes	2 🔯 No live Dates:		1 □ Yes 2X No	Specify:			Sp	ecity: WHI	HITE				
The state of the s	9	2 hou atura	ted	15. Decedent's E	ducation		16a. Deced	dent's Usual Occi	pation			16b. Kind	of Business/I	ndustry				
The state of the s	215	thin 7	npie				life.	DO NOT use retir	ed)		g							
The state of the s	2	led wi lygien her th	Con		•		F'A	CTORY			/Ciaco Adiaballa			JRING				
Approximate control of the state of the stat	ano	d be fi	Be c			. LIPP	Y						1					
Approximate control of the state of the stat	2	should nd Me mark matle	ř					ng Address (Stree						ip Code)				
Physician Medical Examiner Ph	ž	alth a		DANIEL RILEY	- COUS	SIN	3281	GRAFT	ON ST	., M	ANCHE	STER	, MD 2	21102				
Physician Medical Examiner Ph	ore	of He			Removal from	/	Place of Disponentery, crer	sition (Name of natory or other pi	ace)			20c. Local	tion - City or T	own, State				
Physician Medical Examiner Ph	Ĕ	Pag tment tent: I		4 □ Donation 5 □ Other (Special	fy)				REMAT(OŔY								
Physician Medical Examiner Ph	Bai	Depar mpor mpor any in		21. Signature of August Lice	nsee													
Physician Medical Examiner The Company of the Comp				23a. Part1. Enler the disease, or con	nplications that	caused the deat							rer, r	Approximate	Э			
Due to (br as a consequence of): Superiside seconditions say, leading seconditions sa		Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on	each line.			-		1		1					
Due to (or as a consequence of): Due to (or as a consequence of):		/Medical			a. Due to	(or as a conseq		<i>y</i> , , ,	ruvu	, Con				190	3			
Due to (or as a consequence of):		Examiner		Sequentially list conditions														
Section Sect		ed isit	iner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):											
Section Sect		xecut and	xan	that initiated events	c. Due to	or as a conseq	uence of):						-					
IFFEMALE: 23b. Was decedent pregnant 1 23c. If yes, outcome of pregnancy 1 1 1 23c. If yes, outcome of pregnancy 1 1 23c. If yes, ou	760	ysicier e buri	calE		d													
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 29. Subject of Death (Check only one) 28. Date of Injury at Work? 28. Date of Injury	89	ng phy	Medi	IE EEMALE:														
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 29. Subject of Death (Check only one) 28. Date of Injury at Work? 28. Date of Injury	ã	ath ce ttendi or use	lan/	23b. Was decedent pregnant	1 ☐ Live	birth 2 Feta	Ideath 3		су			230			rear			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 29. Subject of Death (Check only one) 28. Date of Injury at Work? 28. Date of Injury	о О	the de the e	ysic	1 ☐ Yes 2 ☑ No			eath 5∟	Other (specify)	,,					,				
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 29. Subject of Death (Check only one) 28. Date of Injury at Work? 28. Date of Injury		thet I		Part II. Other significant conditions	contributing to	death but not res	ulting in the u	nderlying cause g	iven in Part I.		23e. Did	tobacco use	contribute to	the cause of d	eath?			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 29. Subject of Death (Check only one) 28. Date of Injury at Work? 28. Date of Injury	rds	quire; an signuld be	ed b								10	Yes 2 🖅	√6 3 Pro	bably 4 🗆	Jnknown			
25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 27. Manney of Death 1 Month, Day Year) 28. Date of Injury at Work? 29. Subject of Death (Check only one) 28. Date of Injury at Work? 28. Date of Injury	900	law re as bed 2 sho	plet									an 2	24b. Were aut	opsy findings	available			
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural 2 ER/Outpatient 3 DOA Cther: 4 Mursing Home 5 Residence 6 Other (Specify) 28. Date of Injury 28b. Time of Injury 28b. Tim		The cate h page	Con								perf	ormed?	death?					
29a. Certifying Physician: To the heet of my knowledge doubt commend at the time date and place and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 V. June State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature	Zi S	iclen certifi rector	00	examiner?	Hospital:			1.0	thon	4								
29a. Certifying Physician: To the heet of my knowledge doubt commend at the time date and place and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 V. June State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature	ō	Phys r this ral di			1			I 3L DOA	4 NU					ify)				
29a. Certifying Physician: To the heet of my knowledge doubt commend at the time date and place and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 V. June State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature	<u>0</u>	nding nth. r: Afte e fune	ation			nth, Day Year)												
29a. Certifying Physician: To the heet of my knowledge doubt commend at the time date and place and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 V. June State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature	<u> </u>	r Atte er deg recto	tifica	datamias	200. Plac	e of Injury - At he	ome, farm, str	eet, factory, office	9	28	Bf. Location City or To	(Street and N	lumber or Ru	ral Route Num	ber,			
30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 Victory Street MANCHESTER, MD 21102 State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature		ital or irs aft ral DI																
30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 Victory Street MANCHESTER, MD 21102 State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature		Hosp 24 hou Fune Hely fi	lical	(Check only 2 Medical Exa	miner: On the !	basis of examina	wiedge daall ition and/or in	normitted at the vestigation, in my	tima date an: opinion, deat	d placa, ar th occurre	nd due to the d at the time	date and pl	d manner as ace, and due	stated: to the cause(s)			
30. Name of address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 Victory Street MANCHESTER, MD 21102 State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature		o the	Med		and ma	iller stated.		29c. Lice	nse number			29d. Date s	igned (Month	, Day, Year)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN W. MIDDLETON, MD 3331 Volume State 31. Date filed (Month, Day, Year) 2008 32. Fegistrar's Signature		rsrö		blom U/m	relle	to me	0 —	D2	5443			1/1/2	2/711	2				
State 31. Date filed (Month, Day, Year) 32. Tegistrar's Signature			1	30. Name and address of person who	completed cau			Print)	44									
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								ory J	reet	MA	NCHES	TER,	MD 21	102				
	3.				2008 32	negistrar's Signa	iture	2000										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Josephine Theresa Laing January 17, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Baltimore Timonium If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🗓 F Director 216-24-8988 79 Sept 19,1928 | Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 27 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2X1No Maryland Howard Ellicott City 10e. Street and Number 10g. Citizen of What Country? 4890 Avoca Avenue Funeral 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Itel may Injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Weiss Lillian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4890 Avoca Avenue, Ellicott City, MD 21043 Veronica L. Walsh / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Metro Crematory 1/21/08 Catonsville, Maryland 21. Signature of Funeral Service Liceral Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 23a. Part1 Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or hear failure. List only one cause one sch line. 10 W. Padonia Road, Timonium, MD 21093 SIOVERCOLEY 1/12242 Immedia e Cause (/ inal disease - condim n resulting in death) **Physician** Due to (or consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the deeth certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physiclan for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Sursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29b. Signature and til 29d. Date signed (Month, Day, Year)

State

State Registrar

DHIVIH 17 Rev 1/2001

1 2 2 2008 Acces to free

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY ROAD

TIMONIUM

MD

21093

				Plea	se Type o									•	e.	
			For State		State	of Ma	arylan				lealth and	Mental H	, 0	000	0 01	102
	180	Si I	State Registrar 1. Decedent's Name	e (First Middle	e Last)			Cei	runca	ie oi i	Death	2. Date of D	Reg. No	<u> </u>	3. Time	of Death
	Physicia				,							Month	Da	y at	ear 8:10	PM
	/Medic		Norman F 4a. Facility Name (I	f not institutior	n, give street and						Location of Deal	th	4c	. County of	- 2	
	Š	MV A	VAMARYL			SAF	SYST	EM	,	-	4 POIN			jeci	1	
	Funeral		5. Social Security N		6. Sex 12X M 2 ☐ F	=		as <i>t birthd</i> ay) Yrs.	If Und Months	or 1 Year Days	If Under 24 Hrs Hours Min	. (Month, E	Day, Year))	Birthplace (State Country)	_
	Director		220-40-95 Usual Residence of				63	.,,,,				Feb.	20, 1	944	Maryla	na
rylanc	how		10a. State	10b. County			10c. City	, Town or Lo	cation						10d. Inside	1
ie Ma	8a-f s	Director	Maryland		rford			Aberde								s 2⊠No
with th	a or 2 be no		10e. Street and Nur						10f. Z	ip Code	01.001		10g. Cit	tizen of Wha		
eath	ns 23a must	Funeral	4007 Le	e Road	12. Was D	ecedent I	Ever in U.	S. 13.	Was Dec		21001 Ispanic Origin? (Specify Yes or N	10-	USA 14. Race -	American Indian,	
fferd	r Iten	Fun	1 Never Marr	ied 2□ Marr	Armed	l Forces? es 2 ☐ N Give		}			lispanic Origin? (an, Mexican, Pue	rto Rican, etc.)			White, etc.	
ours a	ral", o Exan	l by	3 ☐ Widowed	4 Divorced	If Yes, Year o	Give or Dates:			1 ∐ Yes	2 √2 No	Specify:			Specify:	White	
72 h	"natu dical	Completed	(Spec	15. Deceden	t's Education st grade complete	ed)		16a. Dece	dent's Us	ual Occup ork done o	ation during most of wo d)	orking	16b. K	(ind of Busin	ness/Industry	
within	than	dmo	Elementary/Seco	ndary (0-12)	Colleg 2	je (1-4or 5	i+)		itar		1)		11	s co	vernment	
iled	Hygi other ent, t	BeC	17. Father's Name	(First, Middle,					-		18. Mother's Na	me (First, Midd				
ad blu	henta rked tic ev	To B	Walter	Ray Li	.les						Sophi	a Aleen	e May	?		
2 shoi	and his ma		19a. Informant's N					19b. Mailir	ng Addre	ss (Street	and Number or F	Rural Route Nun	nber, City	or Town, St	tate, Zip Code)	
and	m 27 her tr		Phillip M		s / Son		Jook D	Place of Dispo			925, Col	insville Date				
iges 1	Department of Health and Mental Hygiene. Important; If item 273a or 28a-f show Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			☐ Cremation	3 □Removal#	om)State	C	emetery, cre	matorý o	other plac	i i				ity or Town, State	
it. Pe	artmei ortant injury		4 □ Donation 21. Signature of Fu			/	Ha				Gdn: 1-		Abe	erdeer	ı, Maryla	<u>n</u> d
bern	Deparation Department on Ce			AK		c	TO				ss of Facility Ineral H Sbury Rd			MD 2	21000	
3.9	Van i		23a. Par 1. Enter t	the disease, or	complications the	at caused	the deat								Approxim Interval B	ate etween
Pł	nysician		Immediate Cause	(Final				250:00	ata	y F	-Ailure				Onset and	d Death
	Medical		resulting in death)		Due Due	to (or as	a conseq	uence of):	,	1	FAilure				7 (2)	-0001
=	xaminer	L	Sequentially list co	enditions,			a consequence	MA C) + (UNJ						
ted	nsit	Examiner	Sequentially list confirmany, leading to in cause. Enter Under Cause (Disease or	nmediate erlying injury	S Due	to (or as	a conseq	uence or).								
executed	cian and ourial-transit	Exar	that initiated events resulting in death)	5	c	to (or as	a conseq	uence of):								
te be	ysicia ne bur				d											
artifica	attending physic for use as the bu	Physician/Medical	IF FEMALE:		_											
ath ce	or use	ian/	23b. Was deceden			ive birth	2 Feta	I death 3		pregnancy	у		1	23d. Date Mont		Year
the de	by the a	ysic	1 ☐ Yes 2 l 9 ☐ Unknowr	□No		regnant a nknown	t time of d	leath 5L	Other	specity) _			-			
The law requires that the death certificate be	signed by be deta		Part II. Other signi	ficant conditi	ons contributing	to death b	ut not res	ulting in the u	ınderlying	cause giv	en in Part I.	23e. Di	d tobacco	use contrib	oute to the cause of	f death?
quire	been sign	ed by										. 1[]Yes 2	2 □ No 3	Probably 4	Unknown
aw re	s bee	Completed										24a. W	as an topsy	24b. W	ere autopsy finding for to completion o	s available
The	ate has page 2	Com											rformed?	de	ath? ☐Yes 2☐No	oduse of
cian:	r this certificate hairal director, page 2	Be (25. Was case refe examiner?	rred to medica	11					104		eath (Check onl	y one)			
Physi	r this or	L L	1 ☐ Yes 2 ☐ 27. Manner of Dea			ate of Inju		ER/Outpatie			4 ☐ Nursing	Home 5 ☐ Re				
gling	0 0	tion:	1 Natural	5 ☐ Pendii investi	ng (/	Month, Da	y Year)	Injury	M	28c. Injui Wor 1 🗆	rk? Yes 2∐No	Zed. Descrit	ie now inji	ury occurred	u	
Atten	ctor:	fical	2 Accident 3 Suicide	6 ☐ Could detern	not be 28e. P	lace of inj	ury - At he	ome, farm, st	reet, fact	_					r or Rural Route N	umber,
<u>a</u> o	s after	Certification:	4 ☐ Homicide		Ь	iuliaing, et	tc. (Specif	<i>y)</i>				City or	Γόwn, Sta	re)		
the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur		29a. Certifier (Check only		ng Physician: To I Examiner: On the										ner as stated.	e(s)
the P	hin 24 the F mplete	Medical	one)		and r	manner st										, ,
10	To		29b. Signature and	CHI THE	Mic &	da	MN			m~	DIO	nneglykk	70	M. And	(Month, Day, Year	08
1	χì		30. Name and add	ress of person	who completed	cause of c	death (Iten	n 23a) (Type.	, Print)	IIID	0726	705	013	. 2-11))	
14			Debore		ileck, 1	Y.D.	AV,	WHON	anna.	HEAV	TH CAR	ESYSTER	is, DER	TO FO	e am, foi	1902
	Sta Regist		31. Date filed (Moi	nth, Day, Year	2008	32. Registi	rar's Signa	ature	and the	,						
	1130181	CIL		DENIE TW P	10	The state of	_	W 18								

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician

Exam

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

dical	Dor	<u>ina Ma</u>	rie	Lubin				211110	21.417.1	at the space of	DED TERMIN				
niner	4a. Facility Name (It not institution Saint Jos	n, give street and n eph Medi	mber) Cal Ce	nter	4b. City, Town,	or Location	of Death	on	40	c. County of De	ath altimore				
ai	5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday,	If Under 1 Year			8. Date of Bi	irth	9. Bi	irthplace (State or Foreign				
r	215-80-0940	1 □ M 2 X □ F	48	Yrs.	Months Days	Hours	Min.	Dec. 20	5,19		Maryland				
1	Usual Residence of Decedent 10a. State 10b. County	,	10c City	, Town or Le	ocation						10d. Inside City Limits				
5											1 ☐ Yes 2 X No				
ectc		imore		imoni	UM 10f. Zip Code				40- 0	10					
Funeral Director	10e. Street and Number	itizen of What C													
era	118 Hollow B		cedent Ever in U.S	3 13	Was Decedent of		0-	U.S.A. 14. Race - American Indian,							
ᆵ	1 □ Never Married 2 📜 Mai	Armed F ried 1 ☐ Yes	orces? 2 X No		If Yes, specify Cu	oan, Mexica	n, Puerto R		Black, Wh						
by	3 ☐ Widowed 4 ☐ Divorced	I It Yes. (-	ilve		1 □ Yes 2 💢 No	Specify:				Specify:	White				
Completed by	15. Deceder	nt's Education est grade completed)	(Give	dent's Usual Occu	durina mos	st of working	a			usiness/Industry				
ğu	Elementary/Secondary (0-12)	College	(1-4or 5+)	life.	DO NOT use retire	ed)		9	1	altimore ublic Se	e County				
	17. Father's Name (First, Middle	5+	•		<u>eacher</u>	19 Moth	or's Name	(First, Middle			CHOOTS				
Be		•	Folion	Tue.		TO. MOUTE			z, maiuei	,	•				
P	Orlando 19a. Informant's Name/Relation:		Felice,		ng Address (Stree	t and Numh		monda Boute Numi	her City	Mormon					
	Timothy Lubin		and		Hollow E						land 21093				
	20a. Method of Disposition		20b Pi	ace of Disp	osition (Name of		Da			ocation - City o					
	1 N Burial 2 □ Cremation 4 □ Donation 5 □ Other (State Dui	aney	matory or other play Valley Gardens		1-19-	2008	Tir	monium	Maryland				
	21. Signature of Fundral Service	Licensee		2	2. Name and Addr	ess of Facili					Home, Inc.				
	1050 York Road Towson, Maryland 21204														
	23a. Part1. Enter the disease, o shock, or heart failure. Lis		Approximate Interval Between												
	Immediate Cause (Final disease or condition	a AF	RTERIOS	CLERC	TIC CAF	RDIOV	ASCU	LAR D	ISE	ASE	Onset and Death				
	resulting in death)	Due to	(or as a consequ	ence of):											
_	Sequentially list conditions,	b. ————	/ * * * * * * * * * * * * * * * * * * *	era all											
nine	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury														
Examiner	· · · ·														
edi															
2	IF FEMALE: 23b. Was decedent pregnant	23d. Date of de	elivery												
hysician/Medical	in the past 12 months? 1 □ Yes 2 XNo		birth 2□Fetal gnant at time of de		⊒Ectopic pregnan ☐ Other <i>(specify)</i> _	Month Day Year									
hy.	9 □ Unknow∎														
by	Part II. Other significant condit	_	death but not resu	lting in the u	inderlying cause gi	ven in Part I	l.			P. 2	to the cause of death?				
tea	DIABETES MEI							10	Yes 2	2 No 3 □ F	Probably 4 Unknown				
nple	HYPERTENSION	I	_					24a. Was	psy	prior to	autopsy findings available completion of cause of				
Completed	HYPERLIPIDEN	IIA						perf 1□ Yes	ormed? 2 N	death?	1 .				
Be	25. Was case referred to medica examiner?	Hospital: \	,		Los		e of Death	Check onl	one						
0	1 ☐ Yes 2 No 27. Manner of Dath	X		ER/Outpatie	III OLI DON					6 Other (Sp	ecify)				
ion	1 Natural 5 ☐ Pendi	/8.8	nth, Day Year)	Injury	Wo	ıryaτ ork?]Yes 2∐		8d. Describe	now Inju	ury occurred					
Certification:	3 Suicide 6 Could	not be 28e. Plac	e of injury - At hor	ne, farm. st				Bf. Location	(Street a	and Number or F	Rural Route Number,				
erti	4 Homicide determ	buil	ding, etc. (Specify)	,			City or To							
edical C	29a. Certifier 1 Certifyi (Check only one) Medical	ng Physician: To the Examiner: On the and ma	ne best of my know basis of examinat nner stated.	vledge, deat ion and/or ir	th occurred at the nvestigation, in my	ime, date ar opinion, dea	nd place, ar ath occurre	nd due to the d at the time	e cause(s	s) and manner and place, and du	as stated. ue to the cause(s)				
Me	29b. Signature and title of certific	er			29c. Licen	se number			29d. Da	ate signed (Mor					
	1 Jan	~~~			D3	0263				1-16-	-08				
	30. Name and address of persor	who completed cau	ise of death (Item	23a) (Type,	Print)										
	FRANCIS KH				R DRIVE	TO	WSON.	, MARY	LAN	D 2120	14				
e	31. Date filed (Month, Day, Year		Registrar's Signat		acres 2										
ar	UANA	ي دووو	Carried A	1											

Registrar

State Registrar

anoam

phodite Lambina

31. Date filed (Month, Day, Year)

AMON J. CHARRS NO 6701 N 32. Registrar's Signature

			For	State	of Mai	•	•	rtment of H		and M	lental Hy	giene				
			State Registrar			(Seri	tificate of	Death		0.00	Reg. No.	2008		1.05	
×	Physicia	an	Decedent's Name (First, Middle								2. Date of De Month	Day		3. Unmel of	Deada O	
ja -	/Medic		Steve Ching-Yi		45 City Town	-1	4 De eth	Januar		, 2008 County of Death	7:30	A • 1**				
	Examin		4a. Facility Name (If not institution				4b. City, Town, o		n Death				7			
			2 Scotch Mist C 5. Social Security Number	6, Sex	7. Age	(In yrs. last birth		If Under 1 Year			8. Date of Bi	Montgomery Birth 9. Birthplace (State or For				
	Funeral Director		217-70-4469	1⊠M 2□F		-	rs.	Months Days	Hours	Min.	(Month, D March		1945 Taiw			
	And the second		Usual Residence of Decedent													
	ırytan show 1 at	_	10a. State 10b. County			10c. City, Town Rockvill		ation					1	0d. Inside Ci 1 X Yes		
	e Ma Ba-f s	Director	Maryland Montg	omery		NOCKVII.	T.E	1					(140			
	or 2	Dir	10e. Street and Number					10f. Zip Code				-5	izen of What Cour ted State	•		
	be filed within 72 hours after death with the Maryland that Hygiene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	eral	2 Scotch Mist	12. Was De	andent E	or in II C	10 14	20854	lienanio Orl	ain? (Sn	ooify Vee or N		14. Race - Americ		-	
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Mar	Armed F			lf.	as Decedent of F Yes, specify Cub	an, Mexicar	i, Puerto	Rican, etc.)		Black, White,	etc.		
36	ırs afi li", or xami	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes. G	ive		1	☐Yes 2XINo	Specify:				Specify: Asia	n		
1215-0036	2 hou ature cal E		15. Deceder	nt's Education	4)	16a. [Deced	ent's Usual Occup	ation	a af want	ina	-	ind of Business/In			
215	hin 7	ple	(Specify only higher Elementary/Secondary (0-12)	est grade completed College	(1-4or 5+) '	life. D	ind of work done O NOT use retire	during mos d)	t of work	ing					
2	d wit	Completed			+		rch	itect					chitectu	re		
D	be file tal Hy d oth	Be	17. Father's Name (First, Middle	Last)							e (First, Middle	e, Maiden	Surname)			
<u>ya</u>	Men Men arke	P	Kuo Yen Lin								Su Lin		T 011 7	0 - 4 - 1		
<u>a</u>	12 sh h and 7 is m traum		19a. Informant's Name/Relations Stephanie Lin /			I							or Town, State, Zij ${ t rk, \ \ NY \ 1}$			
e,	1 and Healt em 2 ther		20a. Method of Disposition					sition (Name of natory or other pla			Date		ocation - City or To			
Baltimore, Maryland 21	Pages 1 and 2 should be filed w nent of Health and Mental Hygier int; If item 27 is marked other th iry or other traumatic event, the		1 ☐ Burial 2 ☑ Cremation		n State					Jan.	21, 2008	Reth	nesda, Ma	rvlan	4	
Ξ	permit. Pag Department Important; Ii any injury o		4 □ Donation 5 □ Other (3			rioricgone.	22	Name and Addre	se of Facili	hv		-		A.691	-	
ä	Dep Imp		7.5.6	\checkmark	М	00896	Ro	bert A. O W. Mon	Pumph tgome	rey rv A	Funera ve R	L Hor	me/Rockv: ille, MD	20850	1nc. -2805	
	4	_	23a. Part1. Enter the disease, or shock, or heart failure. Lis	r complications that	t caused t	he death. Do no								Approxima Interval Be		
	Physician [*]	1 1	Immediate Cause (Final disease or condition		homa	•								Onset and	Death	
7	/Medical		resulting in death)	a		consequence of	f):									
Ø	Examiner		Sequentially list conditions	b												
- 10	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, University of that initiated events	Due to	o (or as a	consequence of	f):									
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C	o (or as a	consequence of	f)·									
8760,	icate be executed physician and s the burial-transit	al E	,	Bue i	0 (01 ds d	consequence of	.,-									
687	icate phys s the	dical		d												
Box (leath certific attending p I for use as 1	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c				_					23d. Date of deliv	ery		
ĕ	death atter	icjai	in the past 12 months?	4□Pre	gnant at t	Pretal death ime of death		Ectopic pregnand Other <i>(sp</i> ec <i>ify)</i> _	y 				Month	Day	Year	
<u>Р</u> О	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	9 □Unknown	9∐Unl	known											
	s tha	by P	Part II. Other significant condit	ions contributing to	death but	not resulting in	the un	derlying cause gi	ven in Part I				use contribute to			
g	w require been siç should b										1]Yes 2	Pro 3 □ Pro	bably 4 🙀	Unknown	
မင္ပင	ne law r has be ge 2 sh	ple									24a. Wa	opsy	24b. Were aut prior to co	opsy findings impletion of o	available cause of	
<u> </u>		Completed									per 1∐ Yes	tormed? 2⊠No	death? o 1 ☐ Yes	2□ No		
Vital Records,	ysician: The is certificate hadirector, page	Be (25. Was case referred to medic examiner?					lou		e of Dea	th (Check only	one)				
7	Physi r this c ral dire	은	1 ☐ Yes 2 ☒ No		☐ Inpatier te of Injun	t 2 ER/Out		I 3 DOA		ursing Ho	ome 5 Re 28d. Describe		6 ☐Other (Spec	ify)		
Division or	Jing P	jon:	27. Manner of Death 1 X Natural 5 ☐ Pendi	/4.4	onth, Day	Year) 200. In	ijury	28c. tnju Wo M 1	rk?]Yes 2□	No	200. Describe	s now inju	iry occurred			
<u>S</u>	Attending or death. ector: After by the funer	icat	3 ☐ Suicide 6 ☐ Could	not be 280 Pla	ice of inju	y - At home, fan	m, stre	eet, factory, office			28f. Location	(Street a	nd Number or Rui	al Route Nu	mber,	
<u>≤</u>	5.5, # 6	Certification:	4 ☐ Homicide determ	mined 200. Pro	ilding, etc.	(Specify)					City or T	own, Stat	re)			
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier 1 Certify	ing Physician: To t	the best o	f my knowledge,	death	occurred at the t	ime, date a	nd place	, and due to the	e cause(s	s) and manner as	stated.	(0)	
	To the Hos within 24 hd To the Fun completely	Medical	(Check only 2 Medica one)		anner stat		1/01 111			alli occu						
	To t Withi To tl	Σ	29b. Signature and title of certifi	er / , /	11	di .		29c. Licen	se number				ate signed (Month			
	-		Shaner	e Whole	llw	E mu	()	D006	4615			Jan	uary 19,	2008		
1	167		30. Name and address of perso						1		1_ +1	1	Mover-1 1	20050		
			Genevieve Anne			M.D., 1 r's Signature	355	riccard	ı priv	re, E	KOCKV11	те,	maryrand	20000		
	Sta Registi			1 2 2 2008	La	S. S. Signature	1	fresh !								
DH	IMH 17 Rev 1/2		JAN	4 6 6400	Aller Co.	Milled L	3	A STATE OF THE PARTY OF THE PAR								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 9 per fh 8875 1-25-08 vt. State of Maryland? Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Not 2. Date of Death 1. Decedent's Name (First, Middle, Last) 01/21/2008 **Physician** Theophilia Estelle Mallek а м 6:58 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Ctr. for Hospice Care Towson Baltimore County 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M **XX**F Months Days Hours Min 220-78-9777 98 Director 10-22-1909 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a State 10h County MD Baltimore 1XXYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 2 r must be n 2606 E. Baltimore St. 21224 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 21 No Specify: Specify: White 3 ₩ Widowed 4 Divorced "natural", other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Be Paul Perzynski ျှ Stella Budka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emil T. Mallek / Son 2823 Elliott St., Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State permit, Pages 1
Department of H
Important: If ite
any injury or ot
once, Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore, MD Holy Rosary Cemetery 01/25/2008 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 2818 E. Baltimore St., Baltimore, MD 21224 21. Signature of Funeral Service Licensee M01452 land 5 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician STOKE Weeks /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death ce tificate be executed ing physician and as the burial-trans Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): ttending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Deinenna 1 ☐ Yes X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 perform 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Will Will 1 Yes 2 No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: 6 Could not be determined 3□ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 21 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w N. Charles St Towson MD 21204 674 32. Registrar's Signature 31. Date filed (Month Pan State

Registrar

January 21,2008 (,584

Ineo

		1 - For State Registrar		f Maryla	nd / Dep		t of H	ealth a			jiene 10g. No.2	008		107	
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, I Ben A. Moore J 4a. Facility Name (If not institution, g 51 Baldridge Re	r nive street and nur	mber)			Town, or	Location o	of Death	2. Date of Dea Month Januar	y 4,	2008 ounty of Deane Aru	7:15	of Death AM M	
Funeral Director				7. Age (In yrs	s. last birthday) Yrs.			If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 5,	, Year)	C	thplace (State ountry) SISSIP		
r 28e-f ehow	rector	MD Anne A	runde1	City, Town or Lo Annapo		Code				l 0g. Citize	n of What Co	L	City Limits es 2 No		
tems 23a o	Funeral Director	51 Baldridge Ro	12. Was Dece	rces?	U.S. 13.	Was Deced		401 spanic Orig	gin? (Spe	city Yes or No- Rican, etc.)	USA 14		erican Indian,		
thin 72 hours afte B. B. "natural", or I Medical Exemin	Completed by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of the property of the pr	ff Yes, Giv Year or Da Education	ates: ' 43-	-69	1 ☐ Yes dent's Usua kind of wo	2∏ No	Specify:			nite Andustry	unk			
ould be filed wit Mental Hygiens arked other tha atic event, the	To Be Com	12 17. Father's Name (First, Middle, La Ben Adams Moore	5+ st)		lar	nd sur		18. Mothe		(First, Middle, Alethia		,	1		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: if liem 27 is marked other than "natural; or items 23a or 28e-f show eny injury or other treumatic event, the Madical Examiner must be notified at other.		19a. Informant's Name/Relationship (Type, Print) Mary E. Moore/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 51 Baldridge Road Annapolis, MD 21401 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)													
permit. Depertm importar eny inju		21. Sign sture of Euneral Sprice Lice RO	ensee Wad D	irecto	Ba	11timo	re,	MD 2	21201	655 W.		imore	Street	Ē	
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events													
ate be nysicie he bur	Physician/Medical Exa	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1													
quires that the de in signed by the a uld be detached	ρ	9 □ Unknown Part II. Other significant conditions	_	the cause o	f death?										
	Completed	25. Was case referred to medical									ned?	prior to death?	utopsy finding completion of 2 No	s available cause of	
ng Pnys fter this neral dii	10 B	examiner? 1 Yes 2 Qo 27. Manner of Death 1 Accident 1 1 2 3 3 3 3 3 3 3 3 3	28a. Date o (Monti		ER/Outpatier 28b. Time of Injury		A Other Bc. Injury Work	r: 4 □ Nur at	sing Hon	Check only on ne 5 Reside 8d. Describe ho	ence 6	Other (Spe	cify)		
pitel or Attendius after death. Brat Director: A liled in by the fu	i Certification;	3 Suicide 6 Could not 4 Homicide determine	d 286. Place buildin	ig, etc. (Speci						8f. Location (Si City or Town	i, State)			imber,	
to the hospitel of Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medicai	29a. Certifier (Check only one) 29b. Signature and title of certifier	Physician: To the aminer: On the ba and mann	sis of examina	owledge, death	estigation,	in my opi	inion, death	d place, a h occurre	d at the time, d	ate and pl	ace, and due	to the cause h, Day, Yaar)		
		30. Name and address of person who	completed cause	e of death (fter	m 23a) (Type,	Print)	D3	070	all a	01110-0-	1/1	1/08	1401		
Stat Registra		31. Date filed (Month) Day Year) 2	2008 32. 8	gistrar's Sign	ature	CDICI	ic pe	IKW!	m1 ₁ A	NNAPO	UIS,	110 2	101		

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Division or Vital Records, P.O. Box 68760,

			Plea	se Ty	pe or P	rint in	Black	lne	delible Ink	. Ens	ure A	II Copies	s Are	e Legi	ible.	
		For		5	State of	Maryla			artment of			lental Hy	/gier	ne		
		State Registrar						Cer	rtificate of	Deati	h 		Reg. N	No. 2	100	01100
Physicia	ın	1. Decedent's Nam	ne (First, Midda									Date of Demonstration Month		Day C) U O	3. Time of Death
/Medic	-	Mar		٠.	McGi							Januar	_			4:41AM M
Examin	er	4a. Facility Name (i		-		oer)			4b. City, Town,				4	4c. Count	y of Death	
	St.	5009 01 5. Social Security N		t Roa		Aso (In u	rs. last birt	h day)	Randa If Under 1 Yea		own er 24 Hrs.	8. Date of Bi	rth			imore
Funeral Director					/ 2[X F ′		\	Months Days			(Month, D	ay, Yea		place (State or Foreign		
45 46	ŀ	214-26-62 Usual Residence of				/	9					June 9	, I	920	L	MD
yland Jow		10a, State	10b. County	'		10c.	City, Town	or Lo	cation							0d. Inside City Limits
a-f sl	Director	MD	Ва	ltimo	re		Ra	nda	11stown							1 □Yes 2X No
or 28	Dire	10e. Street and Nu	mber						10f, Zip Code				10g. (Citizen of	What Coul	ntry?
ath w	ral	5009 0	1d Cou					,	2113	_				US		
er deg tems ter m	Funeral	11. Marital Status			. Was Deced Armed Ford	es?	U.S.	13. \	Was Decedent of f Yes, specify Cu	Hispanic (ban, Mexic	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	0-		ce - Americ ick, White,	
s afte	by F	1 ☐ Never Marr 3 ☐ Widowed			1 ☐ Yes 2 If Yes, Give Year or Dat	21			1 ☐ Yes 2 🎇 No	Specia	fy:			Specia		
hour tural	ed t	0 🗆 Widowed	15. Deceder			co.	16a.	Decer	dent's Usual Occi	pation			T 16b.	Kind of F	Wh:	
in 72 n "na Aedic	Completed	(Spec	cify only highe		completed)	for C.)	_	(Give	kind of work done DO NOT use retir	e durina m	ost of work	ring				,
with giene r thau	E O	12	ondary (0-12)		College (1-4	ior 5+)]	Homemake	r					Own	Home
al Hyg othe vent,	BeC	17. Father's Name	(First, Middle,	Last)						18. Mot	ther's Nam	e (First, Middle	e, Maid	len Surna	me)	
uld bu Menta rrked tic ev	To E	Thomas V	W. Daws	son							Della	a Mae G	ram	s		
sho and f and f sma		19a. Informant's N	ame/Relations	ship (Type	. Print)		19b.	Mailin	ng Address (Stree	et and Num	nber or Rui	ral Route Numi	ber, Cit	y or Town	, State, Zip	Code)
and 2 ealth n 27			cGinn		Hus	band			Old Cour	ct Ro						1133
of H		20a. Method of Dis 1 XBurial 2	•	3 ⊟Ber	noval from Si	- 1	o. Place of cemeter	Dispo v, cren	sition (Name of natory or other pl	ace)		Date	20c.	Location	- City or To	own, State
Pag ment ant:		4 ☐Donation	5 Other (8	Specify)			arkwo	_	Cemeter	-	1/19	9/08	В	altir	nore,	MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	uneral Service	Ligensee	1/2/				. Name and Add		•					m Road
<u> </u>		u		M	rai	us	u-	-	ine Fune			Reist		stown	, MD	21136
		23a. Part1. Enter t shock, or hea		r complica t only one	itions that car cause on ear	used the de ch line.	eath. Do n	ot ent	er the mode of dy	ring, such	as cardiac	or respiratory	arrest,			Approximate Interval Between Onset and Death
Physician		Immediate Cause disease or condition resulting in death)	on	a	1en	a (Cell		arcin	mo						i mouth
/Medical Examiner		recording in death,			Due to (o	r as a cons	equence o	f):								
* **	<u>.</u>	Sequentially list co if any, leading to in cause. Enter Under	onditions,	b	Due to (o	r as a cons	sequence o	f):								
nsit	Examiner	cause. Enter Under Cause (Disease or that initiated events	erlying injury	<				,								
e executed ian and urial-transit	Xai	resulting in death)	s Last	C. ,	Due to (o	r as a cons	equence o	f):								
e be ex	=			€ d												
Attending Physician: The law requires that the death certificate be executed reath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica													T		
th cer endin	an/N	IF FEMALE: 23b. Was deceden		230	. If yes, outco			зГ	Ectopic pregnan	CV					ate of deliv	•
ed for	sici	in the past 12 1 ☐ Yes 2 l	□No		4□Pregna 9□Unknov	nt at time o			Other (specify)		. –			M	onth	Day Year
at the by the	hy	9 □ Unknown														
w requires that the de been signed by the s should be detached	by	Part II. Other signi			4		_				rt I.					he cause of death?
requir sen s rould	ted	Chron	ne o	hstre	true	folim	mar	7	diseas	e		1 🔀	Yes	2 □ No	3 Proi	oably 4 ∏Unknown
ne law has b	nple												opsy	1	prior to co	ppsy findings available mpletion of cause of
Physician: The la r this certificate has ral director, page 2	Completed											perf 1∐ Yes	2 X	? No	death? 1 □ Yes	2×No
Iclan certifi ector	Be	25. Was case reference examiner?		_	spital:				- 10		ace of Deat	h (Check only	one)			
Physical this call direct	ဥ	1 ☐ Yes 2 2 27. Manner of Dear		110	28a. Date of		ER/Out		1 3 DOX		Nursing Ho	-			her (Speci	(y)
ding Ph T. After th funeral	ion:	1 Natural	5 ☐ Pendir	ng igation	(Month	Day Year) 200. In	jury	W	uryat ork?]Yes 2	ПМо	28d. Describe	now in	ijury occu	rrea	
death ctor: / the	cat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could	not be	28e. Place o	f injury - A	t home, far	m. str	eet, factory, office			28f. Location	(Street	and Num	ber or Run	al Route Number,
lor A after Dire	Certification:	4 ☐ Homicide	detern	ninea	building	g, etc. (Spe	ecify)	,	,,			City or To				arroute runneen
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		29a. Certifier	1 Certifyi	ng Physic	ian: To the b	est of my l	knowledge	death	occurred at the	time, date	and place,	and due to the	e cause	e(s) and m	nanner as s	stated.
e Ho 124 h e Fui iletely	Medical	(Check only one)	2 ☐ Medica	l Examine	r: On the bas and manne	sis of examer stated.	ination and	l/or in	vestigation, in my	opinion, c	death occur	rred at the time	e, date a	and place	, and due t	o the cause(s)
To th Withir To th	Me	29b. Signature and	title of certifie	er	7 12				29c. Licer	ise numbe	r		29d. l	Date sign	ed (Month,	Day, Year)
		15 00	20	//		-		>		0514	26		J	anus	2011	15 2008
1	ļ	30. Name and add	ress of person	who com	pleted cause	of death (I	tem 23a) (Гуре,	Print)						7	, 220
4		Elliot	Rothso	chile	1 40	20	old	Ca	ert R	wad	Pih	escille	2,	m/	2 (15,2008
Sta		31. Date filed (Mor	nth, Day, Year	2 20	32. Re	jistrar's Sig	gnature	A	boots				1			
Registr	ar		JANA	H 40	1	Contraction of the Contraction o	w.Pad	-	Con							

Registrar

State

YOUG EASTERN AVENUE, BALTIMORE, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

KEVIN B. GEROLD,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryla		artment rtificate			and M		2111) 8	01110
			Registrar 1. Decedent's Name (First, Middle, Last)		timoate	0, 1			2. Date of Dea	Reg. No.		3. Time of Death
	Physici	an	DORIS	,	MA	400	57 (Month JANUAR	Day	Yeer	
	/Medic		4a. Facility Name (If not institution, give	street and number)	('')			Location o	of Death	31190111	4c. County		
1	Examir	ier	MANOR CARE					SON			BAC		
	Funoral		5. Social Security Number 6. Se	x 7. Age (In yr	s. last birthday)	If Under	1 Year	If Under 2		8. Date of Birt	4- 4-		place (State or Foreign ntry)
	Funeral Director				35 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day March	1922	Cou	MD
			Usual Residence of Decedent			1							
	ylan how		10a. State 10b. County		City, Town or Lo	ocation		,					10d. Inside City Limits
	B-f s	to	MD Balt	imore I	Essex								1 ☐ Yes 2 ☑ No
	th th	lre	10e. Street and Number			10f. Zip	Code				10g. Citizen of V	/hat Cou	intry?
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madigal Examinat must be notified at	Funeral Director	815 Myrth Ave	nue			212	221			USÂ		
	dea dea	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)	14. Race	e - Ameri k, White,	ican Indian,
9	or It	F	1 Never Married 2 Married	1 ∐ Yes 2 ∐ KNo If Yes, Give		1 ☐ Yes 2				, , , , , ,	1	Wh	
21215-0036	ural',	d by	3X Widowed 4 □ Divorced	Year or Dates:			10						
5-	72 t	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dece	dent's Usua kind of won DO NOT us	l Occupa k done d	ation <i>furing m</i> ost	t of work	ing	16b. Kind of Bu	siness/Ir	ndustry
12	within han	μ	Elementary/Secondary (0-12)	College (1-4or 5+)		ecret					Faco	32 T	ibrary
7	2 should be filed with and Mental Hygiene. is marked other than aumatic event, than		12th 17. Father's Name (First, Middle, Last)		30	ecret	-ary		r'e Name	(First Middle	Maiden Sumam		TDIGITY
anc	ntal F	Be	Edgar Croop							renner		3/	
<u> </u>	J Men nark natio	²		on a Cainth	40h Maili		(C+					Ctoto 7	in Cordo)
Maryland	12 st h and 7 is n Iraun		19a. Informant's Name/Relationship (T) Nancy Maldeis			-					r, City or Town,		MD 21784
	1 and Health tem 27		20a. Method of Disposition							Date T	20c. Location -		
Baltimore,	50		M□ Burial 2 □ Cremation 3 □ F	Tenioval Itolii State	Place of Dispo								
ţ	t. Pa tmer tant ijury		' 4 □ Donation 5 □ Other (Specify)		ak La						Balti		
Bal	permit. Page Department o Important: If any injury or once.		21. Signatur of Funera Service Lens	BB Commeller							Ave.		
	40 = 6 G		pary juin	John 1							of Es	sex	Z I Z Z I Approximate
			23a. Part1. Enter the disease, or combo shock, or heart failure. List only o					g, such as	cardiac	or respiratory ar	rest,		Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a P 6	EMER	JTI,	A						
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):								
		_	Sequentially list conditions,	b. Due to (or as a cons	naugnos of):							-	
	ed tisi	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a corrs	equence or).								
_	and and I-trar	Examiner	that initiated events resulting in death) Last	C. Due to (or as a cons	aquence of):								
760,	death certificate be executed e attending physician and of for use as the buriat-transit	ical E		220 10 (01 40 4 2010)	-4-0.100 0.71								
687	physi the			d									
×	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of preg	nancy						23d. Dat	o of dolin	(0.0)
Вох	atten for u	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	ital death 3	Ectopic pre Other (spe					Moi		Day Year
o.	the d	yslo	1 □ Yes 2 ☑No 9 □ Unknown	9□ Unknown	- GGUIII	_ Other (spe	July)		_	3-4			
Q	The law requires that the de ate has been signed by the a page 2 should be detached		Part II. Other significant conditions co.	ntributing to death but not re	esulting in the u	nderlying ca	use give	en in Part I.		23e. Did to	obacco use conti	ibute to	the cause of death?
Records,	uires n sign Id be	d by								101	res 2□No	3 ☐ Pro	bably 4 Hunknown
Š	w requ	Completed								24a. Was	an 24h 1	Moro out	opsy findings available
360	has has je 2	ш							-	autop	SV C	rior to co	ompletion of cause of
<u></u>										1 ☐ Yes	2 □ 100 1	☐ Yes	2 No
Vital	Physicien: this certificatal director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	ac	/	n (Check only o			
of	Phys this ral dii	<u>۲.</u>	1 ☐ Yes 2 ☐ No	I L Inpatient 2			A	4 4-50	_		tence 6 □Othe now injury occurr		ify)
	ding f h. After funer	tlon	1 ■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	Injury	м	Bc. Injury Work	(? Yes 2 □ I		200. 200020	.ov wilary occur	-	
<u>S</u>	l or Attending after death. Diractor: After I in by the fune	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, str					28f. Location (5	Street and Numb	ar or Rur	ral Route Number,
Division	- E E	Certification;	4 Homicide determined	building, etc. (Spe	cify)	oot, lastory,	, 011100			City or Tox			
5	Hospital or 24 hours afte Funerel Dir tely filled in		29a. Certifier 1 Certifying Phy	sician: To the best of my k	nowledge, deat	h occurred a	at the tim	ne, date and	d place.	and due to the	cause(s) and ma	nner as	stated.
3)	the Hospital hin 24 hours a the Funerel I mpletely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of examinand manner stated.	nation and/or in	vestigation,	in my or	oinion, deal	th occurr	ed at the time,	dato and place, a	and due t	to the cause(s)
	To the Hospital of within 24 hours af To the Funerel D completely filled in	Me	29b. Signature and title artifie	2		29c.	License	number			29d. Date signed	(Month,	. Day, Year)
	- 5 - 0) Cl		.0.	7	>5-	7722	_		TANIJAA	y ~	2 2008
_	1		30. Name and address of person who co			1					JIT/VV/T/C	.1 2	- 2008
2	1		LEONARD RICHARDSON	`			5 RI	010 H	300	PILLER	VILLE	un !	2.12.08
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature			177 11	,,,,	111707	1.200	· · ·	<u></u>
	Registr	- 518	IAN 2 2 2	800 a 1800	1 1	soote.	9						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** January 19, 11:20P M 2008 Dorothy Virginia Mumma /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F Director 217-18-2538 88 12/16/1919 Maryland Usual Residence of Decedent a or 28a-f show be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Hydes 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a ciner must be 21082 6607 Williams Road U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 🏖 No þ Specify: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oftn any linlury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Percy Foard Lola LaRue Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Carol Hamilton (sister) 5618 Gondolier Drive - New Bern, North Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fork_U.M. Church Cem. 01/26/2008 | Fork, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6. casaln 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 days Pneumonia /Medical Due to (or as a consequence of): Examiner Congestive Heart failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 years Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician the burial Physician/Medical as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Dav Year 5 Other (specify) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page perform es 2 Physician: 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Peath 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying hysic n: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely xaminer On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onli 2 Medical 29b. Signatu 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JAN 22 2008

Rodney W#11iams M.D.-GBMC 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

6701 North Charles Street, Baltimore, Maryland

Yumma,

r Print in Black Indelible Ink. Ensure All Copies Are Legible. TEM#10e 18 19b perFH 0875 1/25/08 WS of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 12:00 PM Giuseppe Manna January 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☑ M 2 ☐ F Director 85 Sept 16,1922 Italy None Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Ellicott City Howard 10e. Street and Number Woodchase 6332 Wood Chase 10f. Zip Code 10g. Citizen of What Country? death with Court 21.043 Italy Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 X No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within alth and Mental Hygiene.

27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Civilian Worker US Navy 18. Mother's Name (First, Middle, Maiden Surname)
Pecorario
Anna Pecorio 17. Father's Name (First, Middle, Last) Be Tommaso Manna 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra 6332 Wood Chase Court Ellicott City, MD 21043 Paola Manna/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1-23-2008 Marriottsville, MD Crest Lawn Mem. Park 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. ture of Funeral Service M01044 (D 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** montho /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9□Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No The law 24a. Was an page 2 s certificate has autopsy 1□ Yes 2☑No Division or Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 2 No 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA this SALCE 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After ' To the Hospital or Attending 5 Pending investigation 1 Natural Injury death. 1 🗌 Yes 2 🗌 No 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 10 1. Ri 670

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day

32 Registrar's Signature

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

attending physician and for use as the burial-transit death certificate be executed i signed by the ail To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:45 P M Donald Stewart McIntire January 2008 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George Laurel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days Hours Min. 1X M 2 □ F 026-12-1453 86 October 3,1921 Mass Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 No Director MD Prince George Laurel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15743 Haynes Road 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1943-59 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 XNo Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur F. McIntire Edna Florence Braver ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) /spouse Caryl McIntire 15743 Haynes Road, Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory Jan 14, 08 Odenton, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave. Laurel, Maryland 20707-4389 21. Signature of Funeral Service License Work M00773 23a. Part1. Enter the intersection of the complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in the list only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus Fina disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Cardiomyopathy 25 days Sequentially list conditions Examiner It any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Drug to (or as a gonse juence of) Coronary Artery Disease Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Septicemia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Renal Failure 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔣 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D24283 1.13.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11) *1 13631 Baltimore Avenue, Laurel, Maryland 20707 M. Yusef, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 2 2008 W. And

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Muzselman III Roland 80 6745 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nolis Bru 8. Date of Birth (Month, Day, Year)
Aug. 27, 19 If Under 1 Yea If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1XM 2□F 214-78-0303 Director 1959 48 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Director 1 ☐ Yes 2X No MD Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be none. 309 Revell Highway 21401 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 (ZNo 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Owner Elementary/Secondary (0-12) College (1-4or 5+) Auto Body Auto Body Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roland P. Musselman II 2 Therese Mary Jazwinski 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms Janis E. Musselman, 19931 Sweetgum Circle Germantown, MD 20874
se of Disposition (Name of Date 20c. Location - City or Town 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 23, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) Glen Haven Mem. Park 2008 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility $Singleton\ Funeral\ \&\ Cremation$ 2nd Avenue, S.W. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cata strophec disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MRSA autre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and a for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Récords, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perforn this certificate 2**K** No spital or Attending Physician: nours after death.
neral Director: After this certificat if filled in by the funeral director, pt 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 2 ō 28a. Date of Injury (Month, Day 27. Manner of Death 28b Time of Certification: Injury at Work? Division 1 Naturai 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00061 08 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

State Registrar 1401

Medica

32. Registrar's Signature

2001

Year) 22

31. Date filed (Month, Day,

State Registrar

mp

31. Date filed (Month, Day, Year)

JAN 2 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year ROBERT W. MADSEN 3008 1.06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Haspital zHinor inai ar If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1**X** M 2 □ F Director 68 6/15/1939 216-32-8235 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show notified at 1 ☐ Yes 2 No Director MD BALTIMORE PIKESVILLE 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ь must be 23a 6 EDEN ROC COURT 21208 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Examiner 1 XYes 2 No If Yes, Give Year or DatesVIETNAM 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 10 1 ☐ Yes 2 ☐XNo Specify **p** Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE "natural". Completed 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PROGRAMS MANAGER WESTINGHOUSE 8 YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM MADSEN P EMILIA DEGUDUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum SHARON L. MADSEN/WIFE 6 EDEN ROC COURT PIKESVILE, MD 21208 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) PARKWOOD CEMETERY 1/21/2008 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Yu C /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him deat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 20 No certificate 1∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director; filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 24 the 29b. Signature and Itla of certifier, 29c. License number 29d. Date signed (Month, Day, Year) ise of Geath (Item 23a) (Type, Print) Name and address of person w 0 4000 OLD COURT RD. SUITE 301 PIKESVILLE, 31. Date filed (Month, Day, Year) 32. Registrar's State

DHMH 17 Rev 1/2001

Registrar

2 2

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day JANUARY 20. Year 221218 8:45AM Marlowe, Jr. Thomas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Joseph Medical Center Saint Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6 Sex 9. Birthplace (State or Foreign 1☑ M 2□ F Feb. 22, 84 217-18-9298 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Md. Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21 093 2525 Pot Spring Rd. K-507 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 ☐ If Yes, Give Year or Dates: 2□No 1 Never Married 2X Married 1 ☐ Yes 2X No Specify. Specify. White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Police Officer Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Thomas Marlowe, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Pot Spring Rd. K-507 Timonium, Md. 21093 Mrs. Barbara Marlowe/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Mem. 1-24-08 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Ruck Towson Funeral Home, 21. Signature of Funeral Service Lice dee 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) UROSEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1X Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No

/Medical Examiner and

Physician Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

traumatic event, the M-dical

d 2 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n:

s 1 and 2 st of Health ar if item 27 is or other tr

permit. Pages 1
Department of H
Important: If itel
any injury or oth

Director

Funeral

ģ

Completed

Be

ပ

the Maryland

death with

72 hours after

3altimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records,

pe

burial-trans the as Ise

attending physician Physician/Medical for ed by the a detached f signed by the þ Completed page 2 should peen certificate has funeral director, Be P After this Certification: ne Hospital or An.

' hours after death.

'al Director: After
' by the fur

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

6 Could not be determined

within 24 hours a

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE. TOWSON. MARYLAND 7601 31. Date filed (Month, Day, M D Year) 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 24034

28f. Location (Street and Number or Rural Route Number, City or Town, State)

te signed (Month, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Anne M McGuir	nes	Ctate of Maryland / Depart	ment of ficate of		ntal Hygier	N C Reg. N	vo. 200	8 0111
Physici Medical Exam		Decedent's Name (First, Middle, Last)	-		Mon	of Death th Da	y Year	3. Time of Death 0348 hrs
Medical Exam	mei	Anne Marie McGuinness 4a. Facility Name (if not institution, give street and number)	14	b. City, Town, or Location		uary 18, 2	2008 4c. County of Death	
		28 Allegany Avenue Suite 1600		Towson	or Dodin		Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year If Und	der 24Hrs. 8. Da	ate of Birth (N	1 //M/DD/YYYY) 9. Bir	
Director		212-08-2354 1 M 2XF 48	Yrs.	Months Days Hou	rs Min. Ju	uly B,	1959 Foreig	en PA
		Usual Residence of Decedent		'				
w any			wn or Location	on				10d. Inside City Limits
land f sho	ō	MD Baltimore Tows	SON .					1 Yes 2XX No
ie Maryland or 28a-f show any fied at once.	rec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	28 Allegany Ave. Suite 1600		21204			USA	
ath wi	ner	11. Marital Status 1 X Never Married 2 Married Armed Forces?		Decedent of Hispanic Or s, specify Cuban, Mexica			14. Race - Amer White, etc.	ican Indian, Black,
ter de ", or i		1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 V No specifi	v.		Specify: With	ite
urs af tural	d b	or Dates:	- transmit	's Usual Occupation (Give		ne 16	b. Kind of Business/	Industry
72 ho n "na al Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	st of working life. DO NO	T use retired)			
0036 vithin ene.	ם	2+		Waitress			Food Serv	ice
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)			er's Name (First, I		,	
21215-0036 uld be filed within 77 Mental Hygiene. marked other than t event, the Medical	Be C	Francis Joseph McGuinness 19a. Informant's Name/Relationship (Type, Print)	40h Marilina		Marie Marie			7.0.1
ID 2 shou and N 7 is n	ို	Anne M. McGuinness (mother)		Address (Street and Nu Halton Road,				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 77 is marked other than "natural", or items 23a or 28a-fish injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 20b. Pla	ce of Disposit	tion (Name of cemetery,			Oc. Location - City or	
DOFE ages 1 at of F t: If i		Temoval non state	matory or oth	. ,	01/22/0		Timonium	Maryland
I ltin nit. Pa artmei ortan ry or		4 Donation 5 Other Specify: Dular 21. Signature of Funeral Service Coensee	ney Ve.	Lley Mem. Gi ame and Address of Facil				
Baft permit. Departi		Mulion		050 York Roa	NUCK	ιοωsor nn. Ma	runerai Arvland 21	Home, Inc. 204
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.						Approximate Interval
/Medical xaminer		Immediate Cause (Final disease a. Aspiration of food bolus						Between Onset and Death
xaiiiiici		or condition resulting in death) Due to (or as a consequence of):						
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	ij	cause. Enter Underlying Cause (Disease or injury that initiated						
lisi d	Examiner	events resulting in death) Last Due to (or as a consequence of):						
xecute	g	d		- . ·				
50, te be executed sysician and burial - transit	ledical	UNPENDED						
876 tificat ng ph	<u>¥</u>	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth		al death 3 Ector	oic pregnancy		23d. Date of deliver Month	y Day Year
Box 68760, edeath certificate be the attending physici ed for use as the burise	sician/M	past 12 months? 1 Yes 2 ✓ No 9 Unknown		er (Specify)				
. BC he dea	Phys	=				Billion		11
that the heed by detac		Part II. Other significant conditions contributing to death but not result Cerebral infarct	ilting in the ur	nderlying cause given in F				the cause of death? bably 4 Unknown
Division of Vital Records, P.O. tal or attending Physician: The law requires that the first after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Completed by	Cerebiai illiaici				la. Was an		utopsy findings available
COFC law re has be 2 sho	ed.					autopsy performe	prior to	completion of cause of
tal Rec cian: The certificate ector, page	ပ္ပြ					✓ Yes 2	No 1 ✓ Y	es 2 No
ital Fician:	Be	25. Was case referred to medical examiner? Hospital:	2/Outrationt	26.Place of Death			·····	
of Vi Phys er this	2	1 Yes 2 No	R/Outpatient Bb. Time of In	e Ben 4	Nursing Home		injury occurred	er: Scene
on of onding Ph. th. :: After t	ioi	1 Natural 5 Pending FOUND: F	OUND:	1 Yes 2	_ Subia	ct choke		
isic Atte er dea rector	icat	28e. Place of Injury - At home	345 hrs e, farm, street	t, factory, office building,	etc. 28f. Lo	cation (Stre	et and Number or R	ural Route Number, City
Division pital or Attent ours after death erral Director: filled in by the	Certification:	Suicide 6 Could not be determined (Specify) Multi-Family		•			e) nue Suite 1600, T	
Division Division Hospital or Attend 24 hours after death Funeral Director: stely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge,		ed at the time, date and p			-	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.						
F \$ F S	Me	29b. Signature and title of certifier		29c. License numbe	er	29	9d. Date signed (Mo	onth, Day, Year)
		Jame Jal Nep		O.C.M.E.		J	anuary 18, 200	8
/		30. Name and address of person who completed cause of death (Item 23		1				
<u></u>		Tasha Greenberg MD. Assistant Medical Examine	er 111 F	Penn Street, Baltim	ore, MD 212	01		
S Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Cost .	B				
Regis	ueu	134 M C COOO	32					

State of Maryland / Department of Health and Mental Hygieneo Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Dav Year Physician Ernest W. Mandeville, Jr. January 17, 2008 11:53 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,)
June 29, 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 □ F New York 045-14-3952 Director 87 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ XNo Director Baltimore Md. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 1055 W. Joppa Rd. #719 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 K Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No δ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) General Motors Executive and 2 should be filed w lealth and Mental Hygier m 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest W. Mandeville, Sr. Ruth Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 2366 Vantage Point Ct. Beavercreek, Oh. 45434 Mr. Geoffrey Mandeville/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Co. 1-21-08 Towson, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Survice License 1050 York Rd. Towson. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cordiomyorath **Physician** Schemic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Director for as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by erebrovas cular discerte 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2.2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1/SNatural Iniury within 24 hours after occur.

To the Funeral Director: After the funeral filled in by the fu 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 17 2008 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) + N. Charles St Busson MD Z1204 ANZON 6701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

MANDENVALLE, ERNEST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** JANUARY 16 MOSS 2008 8:54 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2817 MARNAT ROAD BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Sex 1M M 2□F **Funeral** Months 055-38-5680 61 02/04/1946 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f show Examiner must be notified at MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2817 MARNAT ROAD 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌂 No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No þ Specify: Specify: WHITE 3 Widowed 4 Divorced item 27 Is marked other than "natural", other traumatic event, the Medical Exa Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumant. Elementary/Secondary (0-12) College (1-4or 5+) N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GEORGE S LYNNORE MOSS GARTEN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT GELLER / BROTHER-IN-LAW 207 OLD CROSSING DRIVE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MONTEFIORE 01/20/2008 SPRINGFIELD GARDENS, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mall 8900 REISTERSTOWN ROAD - PIKESVILLE. MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION MYOGARDIAL **Physician** Sudden disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner g physician and death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 3 Hype-dwies tero 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy Normal pressure hydrocephalous performed certificate 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ² 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After th funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural within 24 hours after common to the Funeral Director. Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 030377

State Registrar

10

6503 PARKHEIGHTS AVE

21215

BACTMORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

M-COOPER

31. Date filed (Month, Pay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 8:30 PM M 8 08 **Physician** aviD NUNN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Rossville CARR Baltimore MANOR If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Mgnth, Day) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 1 M 2□F Days Hours **Funeral** Yrs West Virginia 234-56-3356 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2√∑ No Nottingham MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 1 Eastern Avenue Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 11. Marital Status Specify: white 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) industrial Ò coder 9 18. Mother's Name (First, Middle, Maiden Surname) unk Injury or other traumatic event, 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be filk iment of Health and Mental Hytant: If Item 27 is marked oth Be Owen Nunn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Important: If Item 27 is nany Injury or and 1057 Quantril Way Baltimore, MD 21205 David Nunn Jr/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S. Wade, Director 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed mey Due to (or as a consequence of) Physician/Medical 23d. Date of delivery IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant Month Year 3 Ectopic pregnancy 2 Fetal death 1☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ûnknown þ Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy
performed?

1 Yes 2 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4₽ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 1 Yes 2√No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Maryland

Baltimore,

Certification: To 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 29a. Certifier Medical (Check only 29b. Signature and title of certifier

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 82(N. Enton

SHMI

88

Finte 308 BALTIMMEMI)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature SAR O

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Tvisha Norman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Age (In yrs. last birthday, 8. Date of Birth (Month, Pay, Year) Dec14,1978 9. Birthplace (State or Foreign **Funeral** Min. Days 1 □ M 2 🖾 F Hours MD 29 Director 219-94-9765 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at Funeral Director MD 1 ☐Yes 2 ☐ No Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ms 23a or ? r must be n 1812 E. Baltimore St.

1. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? U.S.A. 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1√ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 0 Specify: Black 1 ☐ Yes 2 X No Maryland 21215-0036 Specify Be Completed by 3 Widowed 4 Divorced "natural", r than "natur the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GenesisHealthService 12th Health Care Provider If item 27 is marked other or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 and 2 should be Health and Mental ၉ Nancy Eugenia Williams Melvyn V.Norman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 98 Carver Circle Portsmouth, Va. 23701 Melvyn V. Norman/Father ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Pages ō 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once, GreenmountCrematoryJan23,2008Baltimore,Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Linear CALVIN. BPRESTUNGSTFUNERAL. HOME 21213 23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** WERKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? res 20 No death? 1 ☐ Yes 1☐ Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ER/Outpatient 3 DOA Certification: To 1 | Inpatient After this 27. n r of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 No within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only 🙎 🗔 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pers

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

J. J. Stant

08-00514 Bertram Maurice			or Print in of Marylar	nd / Depa	artme	nt of F	lealth ar					00	0 0110
	1	f- For State Registrar		Cei	rtifica	te of E	Death			Reg	g. No.	UU	8 0112
Physicia	W/	1. Decedent's Name (First, Middle, La	st)							Date of Death Month			3. Time of Death
Medical Examir			MAURICE	NOTTA	GE					Month January 18			0513 hrs
<i>y</i>		4a. Facility Name (if not institution, gi Upper Chesapeake Medi		nber)			City, Town, o Bel Air	r Location o	of Death		4c. County Harford	of Death	
Funeral		Social Security Number 6. 8	Sex 7	7. Age (In yrs. I	last birth	- '' F	If Under 1 Ye			B. Date of Birth	(MM/DD/YYY	y) 9. Birth	nplace (State or
Director		212-52-7723	XM 2 F		46	Yrs.	Months Da	ys Hours		08/06/	1961	Cou	MARYLAND
<i>x</i>	1	Usual Residence of Decedent										·	
w any		10a. State 10b. County		10c. City	, Iown o	r Location						1	10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	후		ORD CO					ST HI	LL		6''' 111		
Mary r 28a ed at	Director	10e. Street and Number				1	I0f. Zip Code			10	g. Citizen of W	hat Coun	try?
ith the		1912 LINCOLN RD		Core and O	- T	10.111		050	. 0 (0	7 M M.	U.S.		Died Brook
ath w	Funeral	1 X Never Married 2 Marrie	Asses of Face		i.S.		pecedent of H , specify Cuba			ify Yes or No- can, etc.)		e - Americ te, etc.	can Indian, Black,
er de		3 Widowed 4 Divorce	1 Yes d If Yes, Give Year	2 X No		1 Y	es 2X N	o specify:			Specify:	BLA	CK
urs af itural amin	후	15. Decedent's Education (Specify	or Dates:	e completed)		ecedent's	Usual Occupa	ation (Give			16b. Kind of B		
72 ho	Completed	Elementary/Secondary (0-12)	College (1-	4 or 5+)	dı	uring most	t of working lif	e. DO NOT	use retired)			
036 vithin ene. er tha	립	12th grade			FI	REFI	GHTER				BALTI	MORE	CO
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Las	t)					18.Mother	's Name (F	irst, Middle, M	aiden Surnam	9)	
121 d be i fental narke	Be	THOMAS E. NOTTAG			T 40h	Mailing A	ddana (Ou			NOTTAGI	E per, City or To	01-1-	Zio Ocato)
MD 2 id 2 shoul ilth and N in 27 is in	ဍ		** '		41		,						
and 2 lealth tem 2	ŀ	Boyton Nottage/E 20a. Method of Disposition	rotner	20b.			 LUZE: On (Name of continuous) 			Baltimo Date	ore, Ma 20c. Location		nd 21224 Town, State
Ore ges 1 st of H		1 X Burial 2 Cremation 3	Removal from	III State		ry or other		·					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other tranmative event, the Medical Examiner must be notified at once.	-	4 Donation 5 Other Specification 21. Sonature of Funeral Service Lic.		BE	RKLE		METERY ne and Addres	se of Eacility	01-2	4-08	DARLIN	GTON	, MARYLAND
Bal perm Depa Impe		21. Sphalure or your erail Service (10)	7300			WIL:	LIAM C	BROW	I COM	M FUNE	RAL HOM	E-HA	RFORD, P.A. MD 21001
Physician		23. Part I. Enter the disease, or com		used the death	n. Do not								Approximate Interval
/Medical	1	failure. List only one capese on a Immediate Cause (Final disease	each line. LAsthma										Between Onset and Death
kaminer	-	or condition resulting in death)	Due to (or as a	consequence o	of):								
		Sequentially list conditions,											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a o	consequence o	of):								
1 _ =	Хащ	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):								
ecuted and transit	-		l				_						
be ex sician urial.	텷	UNPENDED	AMENDED						_				
Box 68760, e death certificate be execut the attending physician and ed for use as the burial - tra		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, or	utcome of preg		- Fotol	death 3	Ectopic	pregnanc	v	23d. Date of Month		y Day Year
x 68 h certi	iciai	past 12 months?		int at time of de	eath 5		r (Specify)	Lotopic	programo	,	Montai		real real
Bo e deat	hys	1 Yes 2 No 9 Unknow	g Unknov	wn									
s, P.O. Box ires that the death r signed by the atte d be detached for u	by P	Part II. Other significant conditions	contributing to	death but not r	resulting	in the und	derlying cause	given in Pa	art I.				the cause of death?
S, P. uires th													pably 4 Unknown
cords, law requir has been s	Completed									24a. Was a autops	sy	prior to c	topsy findings available completion of cause of
Recc The lav	E									perform		death? 1 ✓ Ye	es 2 No
Vital Recysician: The his certificate director, page	B B	25. Was case referred to medical examiner?					26.Plac	e of Death	(Check onl	y one)			
Vit	2	1 Yes 2 No		patient 2 🗸	~			Other ₄			Residence 6	Other	:
aling Pl		27. Manner of Death 1 ✓ Natural 5 □ Panding	.28a. Date o (Month,	of Injury Day,Year)	28b. T	ime of Inju		ury at Work		Bd. Describe h	ow injury occu	rred	
ivisior or Attencath after death Director:	Ĭġ	2 Accident 5 Pending Investiga						Yes 2					
Division of Vital Records, tal or Attending Physician: The law requir is after death. "I Director: After this certificate has been sted in by the funeral director, page 2 should!	Certification:	3 Suicide 6 Could no determin	t be	of Injury - At h	ome, far	m, street,	tactory, office	building, et	c. 28	3f. Location (S or Town, St		ber or Ru	ral Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - ra		29a. Certifier	(Opcomy)	of muliania	100 4-1	h 000	d at the time	data and at	200 00 1 1	to the	(a) and		nd.
To the II. within 24 To the Fi	Medical	(Check only one) 2 Medical Examine	er:On the basis of	examination a	-						. ,		
To To con	Me	29b. Signature and title of certifier	and manner sta	ated.			29c. Licer	se number			29d. Date sig	ned (Moi	nth, Day, Year)

State 31. Date filed (Month, Pay, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Margarita Korell MD.

29c. License number O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 19, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MARY BELL NEIL $\boldsymbol{A}^{\,\mathsf{M}}$ JANUARY 20 /Medical 2008 1:45 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Future Care Chesapeake Arnold Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🕱 F Months Days Hours Director 205-24-5581 Sept. 22 1930 Mexico Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show at Examiner must be notified 1X Yes 2 No Directo MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 or items 23a 695 Carlisle Drive Funeral 21012 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: 2 Specify: White within 72 hours 3 Widowed 4 Divorced "natural" Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Choice Hotels than Elementary/Secondary (0-12) College (1-4or 5+) International 12th Executive Secretary of Health and Mental Hyginitem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Bell Alice Helene Donihee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) A-1150 19a. Informant's Name/Relationship (Type. Print) Mariahilferstrasse 142/DG/Top 6, Wien-Austria Mary-Lynne Francois/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Department of H Important; If ite any injury or of XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gate of Heaven 1/25/2008 Silver Spring, MD 22 Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses)M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. En r t he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of he rt failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage **Physician** Means /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examiner the death certificate be executed Due to (or as a consequence of) physician a the burial-Box 68760 Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.O. by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 Yes 2 No 3 Probably been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 2 1 or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 17 No 1 🔲 Yes 1 Inpatient this 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural sefferde... 5 ☐ Pending investigation 1 TYes 2 TNo 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours 1 Deertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

lame and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Jenni ter Kie 31. Date filed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, JAN 2 Year)

VETERE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

29b. Signature and title of certifier

NICOLE

32. Registrar's Signature

MO

9901 Medical Center Drive, Rockville, Maryland 20850

29c. License number

29d. Date signed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Johnny Ogbuli 02:37AM Januar y 2003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Deuke Medical Center Upper Chesa Bel AIV Hartord 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral X** M 2 □ F Months Days Hours Director 212-25-5837 50 12/26/1957 NIGERIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director MD HARFORD 1 ☐ Yes 2 XNo **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1813 ELOISE LANE 21040 Funeral NIGERIA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: 2 Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Maryland 21215-(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN YEARS HEALTH CARE Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental CHRISTOPHER OGBULI 2 or other traumatic ROSE EGBUGI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health a:
Important: If Item 27 Is
any injury or other trau AMANDA OGBULI/WIFE 1813 ELOISE LANE EDGEWOOD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State OGBULI COMPOUND 4 Donation 5 Dother (Specify) 2/15/2008 ONITSHA, NIGERIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23. 1 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (fas a Insequence of): Physician Shock /Medical Examiner Sepsis of unknown Bhrs Sequentially list conditions, if any, leading to find edicticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dure to (or as a consequence ory: Examine The law requires that the death certificate be executed immuno suppression YEUVS Due to (or as a consequence of) attending physician for use as the buria Box 68760 3 YEars Physician/Medical nelanona 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Ó 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 Rena Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Bowe ischemic 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 9 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ision 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the within 2 Lave 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Physician no 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day Year)

.D. 500 Upper Chesapeake

Joseph.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** PAYLOR AMES 07:10 PM 01 14 2008 /Medical not in titution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3allimore onvalescent Date of Birth (Month, Day, Year) 14. 23, 1930 **Funeral** 9. 8irthplece (State or Foreign Days Months 12 M 2 □ F Hours Director Usual Residence of Decedent with the Maryland 10a. State 10b. County Town or Location 7 is markad other than "neturel", or Itams 23e or 28a-f show treumatic event, the Madical Examination at 10d, Inside City Limits Funeral Director 1 es 2 No 10f. Zip Code 10g. Citizen of What Country? 4218 13 death 12. Was Decedent Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "neturel; or Ita 8lack, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ️ No Specify: 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use etired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) condary (0-12) College (1-4or 5+) horeman Father's Name (First, Midele 18. Mother's Name (First, Middle, Be Maiden Sumame reatom ai annie 19b. Mailing Andress (Str. or Town, State, Zip Code) MD 21133 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Baltomore ☐Donation 5 ☐ Other (Specify) 21. Signatur eral Services 23a. Part T. Enter me disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician TERMINAL DEMENTIA /Medical Due to (or as a consequence of): Examiner CEREBROVASCULAR ACCIDENT if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be exacuted Box 687605 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Dav Year 5 ☐ Other (specify) of Vital Records, P.O. detached 9☐ Unknown cate has baan signed page 2 should be det Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 EN/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After ! 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a, Certifier Policy in the dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number PHYSICIAN 130064533 01. 17-2008

Registrar

DHMH 17 Rev 1/2001

State

MI

LEVINDALE - HEBREW

W. BEZVEDERE

2434

CATRIMATRIC

CT12

BATTIMORE, MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AJANI

32. Registrar's Signature

BABATUNDE

JAN 2

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 23aPtII per me 879,05/23/08dbb

State of Maryland & Department of Health and Mental Hygiene 1- For Amend PII, 25, 27, 28a-f, perME, g879 5/15 Prificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician PROUDFOOT 1:30 WRETTA HAWUARY 15 2003 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** RANDAUSTOUN NORTHWEST +COSPITAL Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 74 23,1933 MD 218-30-0342 Oct. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at an one. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 √ Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21207 6704 Campfield Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 👿 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: <u>م</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary C. Amana ဥ John E. Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Campfield Road, Baltimore, MD 21207 Husband James W. Proudfoot 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/18/08 Cumberland, MD Hillcrest Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Reisterstown, MD 21136 me Eline Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CHRONIC OBSTRUCTIVE PULMONARY Immediate Cause (Final disease or condition resulting in death) DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Congestive Cardiomybpathy 24a. Was an Right femur fracture autopsy performed?

1 Yes 2 certificate 2. No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be niner? Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Z 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death Natural 2 Accident 5 Pending within 24 hours are.

To the Funeral Director: After 1 ☐ Yes investigation Nov. 10, 2007 unk. subject fell 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6704 CAmpfield Rd. Gwynn Oak, MD 1 Secritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 D54352 MD MIRCEA TODOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 OLD COURT ROAD NORTHWEST HOSPITKL DANJALLSTOWN 32. Registra s Signature 31. Date filed (Month, Day, Year) State

Registrar

Steven Dwigt	nt Pi		I- For State Registrar	ate of Maryla	•	artment o <i>rtificate o</i> :			ntal H		Reg. No.	008 0	Ber establish
Phys		n/	Decedent's Name (First, Middl	e,Last)						Date of De Month		3. Time of Dea	
Medical Exa	ımir	-	Steven Dwig 4a. Facility Name (if not institutio				4h Cib. 3	Town and another	f D#	January	15, 2008	2124 nrs	
<i>b</i>			6704 Campfield Road		imber)			Fown, or Location In Oak	n of Death		4c. County o		
Fune	ral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Und	er 1 Year If Un	der 24Hrs	. 8. Date of B	sirth(MM/DD/YYYY)	Birthplace (State or	r
Direct	or		220-92-4251	1 X M 2 F	40	Yrs	Month s.	s Days Hou	ırs Min	02/04	4/1967	Foreign Country) MD	
^		- +	Usual Residence of Decedent		140. 00								1
I ow any	03		10a. State 10b. County		Tuc. City	, Town or Loca						10d. Inside Cit	
ý nylanc sa-f sh	onc i	함	MD 10e. Street and Number			Balti	more 10f. Zig	Code			10g. Citizen of Wh	21	
1 14 (¢) with the Maryl.	iffed a	Director	6704 Campfie	1d Road			1 '	21207			USA	·	
with ms 23,	pe no		11. Marital Status	12. Was Dec	cedent Ever in U			ent of Hispanic C			lo- 14. Race	- American Indian, Blad	ck,
r death or ite	must	Funeral	1 Never Married 2 M	1 Yes	2 X No		•	fy Cuban, Mexica		Rican, etc.)	White	, etc.	
rs afte	miner	<u>۾</u>	3 Widowed 4 X Div	orced If Yes, Give Yes				X No special	<u> </u>	work dono	Specify:	White	
72 hou	ıl Exa	Completed	Elementary/Secondary (0-12)	College (*				rking life. DO NO			TOD. KING OF BU	siness/industry	
5-0036 iled within 72 Hygiene. 1 other than	Medica	du	12				Carp	enter			Cons	truction	
15-0 filed w Hygid d othe	, the !		17. Father's Name (First, Middle,	Last)				18.Moth	er's Name	e (First, Middle,	, Maiden Surname)		
2121 2121 Wental I marked	event	o Be	James W. Prou-			19b. Mailin	a Address			a A. Gr	reen umber, City or Tow	State Zin Code)	
MD 3 d 2 shou lth and 1	matic	٦	Steven D. Prou		. Son	1					ceedom, P		
l and Healt Fitem	r tra		20a. Method of Disposition		20b.		sition (Na	me of cemetery,	1	Date	20c. Location -	City or Town, State	
MOI Pages	r of h		1 X Burial 2 Cremation 4 Donation 5 Other Sp			llcrest		•	1/	18/08	Cumber	land, MD	
Baltimore, MD 21215-0036 Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I filem 27 is marked other than "matural", or items 23a or 28a-f show	njury	Ī	21. Signature of Funeral Service					Address of Faci		118	324 Reist	erstown Ro	
	_	-i	23a. Part I. Enter the disease, or	complications that o	aused the death			Funeral				n, MD 2113	
Physicia /Medic			failure. List only one cause	on each line.			are mode	or dynig, such as	o cardiac c	or respiratory a	riest, shock, or nee	Between On Deatl	set and
t :amin	er		Immediate Cause (Final disease or condition resulting in death)		consequence								
			Sequentially list conditions,	b		0							
		딒빖	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a	consequence	of):							
p	nsit		events resulting in death) Last	•	consequence	of):							
execut an and	al - tra	g eg	X UNPENDED	d								_	
60, ate be hysicia	e buri	leg leg	IF FEMALE:	#23a,27	,permE,ge	36, 2/4/00 cnancy	3 TT				23d. Date of	delivery	
Box 68760, e death certificate buthe attending physic	uneral director, page 2 should be detached for use as the burial - tran		3b. Was decedent pregnant in the past 12 months?	1 Live t	pirth	2 F6	etal death	3 Ecto	pic pregna	ancy	Month	-	'ear
30X death o	for us	ysic	1 Yes 2 No 9 Unk	known g Unkn	ant at time of do	eath 5 O	ther (Spe	ecify)			ki.		
O. E at the call by the	tached		Part II. Other significant condit	ions contributing to	death but not	resulting in the	underlying	g cause given in	Part I.	23e. Did	tobacco use contri	bute to the cause of de	eath?
s, P.O.	l be de	g D								1 Y	es 2 No 3	Probably 4 🗸 Un	iknown
ords w requ	shoule	Completed									opsy p	Vere autopsy findings a prior to completion of ca	
Rec o The la	page 2	Ē										leath? ✓ Yes 2	No
tal F	ector,	Be	25. Was case referred to medical examiner?	Hoonital				26.Place of Dea					
f Vi Physic	ral dir	ၟႍ	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatien		OOA Other 2		ng Home 5	Residence 6 e how injury occurr		
Division of Vital Records, tal or Attending Physician: The law requires after death. After this certificate has been si	e fune	ertification:	1 Natural 5 Pend	(Month	n, Day,Year)	200. Time of	injury	1 Yes 2		280. Describe	e now injury occurr	cu	
/iSiC r Atte ter dea	n by th	licat		stigation 28e. Plac	e of Injury - At h	nome, farm, stre	et, factory	, office building,	etc.			er or Rural Route Numb	ber, City
Divoital o	illed			mined (Specify)						or Town,	State)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	letely t	<u>a</u>	29a. Certifier 1 Certifying Pl	nysician: To the bes		-							
To the within To the	comp			miner: On the basis and manner s		and/or investiga		y opinion, death		at the time, dat			
		_	29b. Signature and title of certifie	-11-1			29	O.C.M.E.	CI		January 16	ed (Month, Day, Year)	
		-	Tamelet Stuff 30. Name and address of person	who completed cause	se of death (Iter	n 23a)							
~ ~~	- 1	1	,		1.00	,							

111 Penn Street, Baltimore, MD 21201

State Registrar

SAL

Pamela E. Southall, MD Assistant Medical Examiner

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician EROME 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Baltmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days, Year) Jan. 19, 19 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Numbe Age (In vrs. last birthday **Funeral** Months 1 ☑ M 2 ☐ F 219-26-7075 66 1941 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Ex-miner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1216 Hillcreek Road Funeral 21122 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 Is marked other than the Longshoreman 12 Longshoreman or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerome Thomas Puller, Sr. Lorraine Lowman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trains Mrs. Carol Puller 1216 Hillcreek Road Pasadena, MD 21122 Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation Jan 20080, 3 ☐ Removal from State Chesapeake Cremation Stevensville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee min 918 2nd Ave., S.W. Glen Burnie, MD 21061 Services value Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) day raia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or at a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the detached 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably 4 Unknown Completed cate has been s page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 10 or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2× No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/200

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Yea

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

EMRI

Year) N 2

29c. License number

Eastern Ar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🙋 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day **Physician** WILLIAM LEROY PRITCHETT SR. 20, 2008 **JANUARY** 9:30 A /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner UPPER CHESAPEAKE MEDICAL CENTER BET. ATR HARFORD If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1⊊ M 2□ F Director 216-36-5044 Usual Residence of Decedent Dec. 31, 1938 Maryland with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1924 Cypress Drive 21015 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2√2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil.
Department of Health and Mental Hygien.
Important: If item 27 is marked other the any injury or other traumatic event, the once. the Police Department Lieutenant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 William Ramson Pritchett <u>Lula Wilburtha Riley</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia L. Pritchett / Wife 1924 Cypress Drive, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 1-24-08 Baltimore, Maryland Balti 21. Signature of Funeral Service Licenses 2. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** day Hemorrhad /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1∐ Yes Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the l To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address person who The cause of death (Item 23a) (Type, Print) M.D. 500 Upper Chesapeake ettrev Inon 31. Date filed (Month Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 00 January 10, am 18,2008 0 (/Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 1 Year | If Under 24 Hrs. Gorma Ivenue Year) 9. Birthplace (State or Foreign Country)
MARYLAND 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth (Month, Day, Security Number **Funeral** 1 → M 2 □ F Hours Days Min 7-03-8058 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1XÍYes 2 ☐ No Director MARYLAND 10g/Citizen of What Country? 10f. Zip Code 10e. Street and Number Be Completed by Funeral NO 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify Specify. BLACK 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SSKAY (GRADE MEK 17. Father's Name (First, Middle, Last) (UNKNOいげ) 18. Mother's Name (First, Middle, Maiden Surname) (MN - UNKNOW) AURA ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) MILDRED ROBINSON BALTIMORE MD 21223 GORM 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 12 BuriaL 2 ☐ Cremation BUTUS CEMETER 01-23 PALTIHORE, MARYLAND 4 Donation 5 Other (Specify) Funeral Service Licenses 22. Name and Address of Pacility 2140 North Fulton Avenue 21. Signature Baltimore Joseph H. Brown Home 1 23a. P. III. Enter the disease, or complications that caused huck, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resiting in death) CEREBRO VASOLAR **Physician** Jems /Medical Due to (or as a consequence of): Examiner seeus A Der Scheater Vasculer Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of, Examiner sician and burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nio 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Ca 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 performed death? 2 XNo 1∐ Yes 2 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 XNo 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient ဥ funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 □ Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

29a, Certifier

ROBERT

4 Homicide

1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifig

2

2

determined

29c. License number

29d. Date signed (Month, Day, Year) 18/08

Medical

W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIBERTO, MD Bank 3508

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

The law requires that the death certificate be executed

has

certificate

this

After 1

Records, P.O. Box 68760,

Division or Vital

To the Hospital or Attending Physician:

death.

and 21215-0036

Maryl

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Ray 12:35 PM 2008 largaret /Medical 4a. Facility Name (If-lot institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Park smm it If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 212.22.7449 1 □ M 2 💢 F 88 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f ehow id 2 should be filed within 72 hours after deeth with the Maryla. Ith and Mantal Hygiene. 27 ie marked other then "naturel", or Iteme 23e or 28a-f ehov 27 ie marked other then "naturel", or Iteme 23e or 28a-f ehov traumatic event, ite Madical Examinate must be notified at Baltimore MD Kandallstow 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Koad Winands 8620 21133 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Fruniture Store 11th grade 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Smith Reddick Emma 2 Hezekiah 19a. Informant's Name/Relationship (Type, Print) (SVC) and 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 8620 Winands Road Randallstown MD 21133 itam 27 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of H Important: If ita eny Injury or ot once. 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery 01.19.08 Woodlawn MD 3 Removal from State 22. Name and Address Facility Valykn C. Greene Furleral DCS 8728 Liberty Road Kandallstown MD 21133 21. Signature of Funeral Service Licensee ighn Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** month Periphocal /Medical Due to (or as a consequence of) Examiner on Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury attending physicien and for use as the burial-transit The law requires that the death certificate be executed maic that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1 Yes 2 No Attending Physician: efter death.

Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide 0 Hospital 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) fo the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 62 151 08 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baska 3455 Deepak 31. Date filed (Month, Day, Year) JAN 2 2 32 Registrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

118.1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 12:20 AMM Jane M. Ross January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Holly Hill Manor Towson If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year)
May 27, 1923 9. Birthplace (State or Foreign Country) New York 1 ☐ M 2 🔯 F 069-20-8561 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Baltimore Md Towson 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21286 USA 531 Stevenson Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify. Specify: white 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 librarian education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Miller Leonora Schweppe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ann Ross/daughter 15 Nighingale Way A2 Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ronald 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wade ∥Di⁄rector Baltimore, MD 21201 23a. Part. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronary 20 years Due to (or as a conseque ce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 →No 1□ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending

Physician /Medical Examiner

the death certificate be executed

Box 68760,

Ö

σ. that

Vital Records,

0

Division

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

ည

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene.

Baltimore, Maryland 21215-0036

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other that any fulury or other traumatic event, the 1 once.

Physician/Medical Examiner

Completed by

Be

Certification: To

signed by

After this certificate has

within 24 hours after death To the Funeral Director:

Attending Physician:

ō Hospital page 2 should be

funeral director,

filled in by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical

2 Accident

3 ☐ Suicide

(Check only

28a. Date of Injury (Month, Day Year) investigation NA

1 ∏ Yes 2 ∏ No

6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ted Houk MM 7402 York Rd +

2008

JAN 2 2

32 Registrar's Signature

Towson UD

Registrar

*

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 19-08 **Physician** Month 5:35 AM 10 oris 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore NSON anor If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗓 F Director 214-01-9111 24-1914 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner miss is a conce. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2 12 No Directo altimore timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 34 212 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ome maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norton P lormollar \mathcal{M} race 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith

20 Name and Address of Faith Baltimore MD 21234 druce Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State Kosedale, 1-26-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeray Chapel + Cremation Services - Parkuilk
18800 Harford Road Parkville mp 21234 tur Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** hronic /Medical Due to (or as a consequence of): Examiner iabetec Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician an burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown t signed by th. الله ولم" 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Mayes 2 No 3 Probably 4 Unknown Completed 24a. Was an certificate has autopsy page 2 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide

or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: Hospital completely

> U State Registrar

31. Date filed (Month, Day, Year) JAN 2

29b. Signature and title of certifier

29a. Certifier

one)

(Check only



and manner stated.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

rd. #209 Timonium, MD yrus Asadi, 20 E. Timonium

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

40054424

29d. Date signed (Month, Day, Year) 1-19-08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 18 RICHARDSON JR. 2008 11:52 AM FRANK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 12008 Saturn Lane P.G. Laurel 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 → M 2 □ F Yrs 82 578-38-4145 Wash. DC **Director** 2-16-25 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. and it flem 27 is marked other than "natural", or items 23a or 28a-f show ant: if Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d, Inside City Limits XXYes 2 □ No Director P.G. MD. Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12008 Saturn Lane 20708 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: **WW** II þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bricklayer Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Richardson, Sr. Velma Stevens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A Richardson/Wife 12008 Saturn Lane, Laurel, Md. 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/25/08 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat. Cem 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. 21. Signature Funeral Service Licensee r1. Eleter the disease, or complications that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. W. HAC Approximate Interval Between Onset and Death Im rediate Cause (Final direase or condition resulting in death) CEREBROVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ous to (or as a consequence of): Examiner Due to (or as a consequence of): physician al Division or Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a ☐Yes 2☐No 9☐Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24a Was an autopsy performed? res 2 12 No page 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 3□ DOA ٩ 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the ft. М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

moch L. Cross M

32. Registraf's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ELIZABETH L. COBBS, M.D, VAMC, 50 IRVING STREET NW, WASHINGTON DC, 20422/688

29c. License number

MD# 13738

29d. Date signed (Month, Day, Year)

JANUARY 18, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State Registrar		Certificate o	f Death			leg. No.	000	3. Time of Death
hysicia		1. Decedent's Name (First, Middle, Las	st)				Date of Dea		20 0 8	4:15 a
/Medic	al	Shirley M. Row	9	45 O'S T	and montion of				unty of Death	a
xamin	er	4a. Facility Name (If not institution, given Brighton Gard		4b. City, Town	bia			I	Howard	100 to a South
neral ector		5. Social Security Number 6. S	ex 7. Age (In yrs. last birt	thday) If Under 1 Yea Months Day		Min. N	Date of Birt (Month, Day May 2,	1929	I 111	place (State or Fore ntry) LNOIS
		Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr	n or Location						10d. Inside City Lin
or 28a-r snow	ō	Howard	E1	licott Cit	v					1 ☐ Yes 2 🔀
notify .	rect	Md		10f. Zip Code				10g. Citizer	n of What Cou	ntry?
38 O	O	8310 Saddle R	idge Terrace	210	143				USA	
ar Dir	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify C	of Hispanic Ori Juban, Mexicar	igin? (Specif n, Puerto Ric	fy Yes or No can, etc.)	. 14.	Race - Ameri Black, White,	
or in	by Fu	1 Never Married 2 Married	1 □Yes 2 1 No If Yes, Give Year or Dates:	1 □ Yes 2 🛣 N	No Specify:	:		S	pecify: Whi	ite
al Ex		3X Widowed 4 ☐ Divorced 15. Decedent's E		. Decedent's Usual Oc	cupation			16b. Kind	of Business/Ir	
acije	Completed	(Specify only highest gra	ade completed) College (1-4or 5+)	(Give kind of work do. life. DO NOT use ret	ne during mos tired)	st of working	,			
1	E O	Elementary/Secondary (0-12)	College (1-401 3+)	Store Man						ocery St
odother than "naturet", or tems 23s of 28s-1 sho event, the Medical Examiner must be nutified at	Bec	17. Father's Name (First, Middle, Last)		18. Mothe		First, Middle, Jinia			
marked imatic ev	To	Shirley G								in Code)
8 8		19a. Informant's Name/Relationship (o. Mailing Address (Stre						
om 27 ther tr		Michael A. Rowe/	SOD 8	310 Saddle of Disposition (Name of the property), crematory or other the same of the same	Klage	Terra	ace El.	20c. Loca	ition - City or T	Town, State
or of		1 Burial 2 Cremation 3	Removal from State	ry, crematory or other	piace)	1/21/2	1		over,Mc	
njury njury		* 4 □ Donation 5 □ Other (Special Strong Line 21. Signature of Funeral Service Line 21.		t Cremator 22. Name and A						y F.H.Ir
important: If ite any injury or of once.		And an PT	MO084		Columb	bia Pi	ke El	licot	t City,	Md. 2104
		23a. Part 1. Enter the disease, or con- shock, or heart failure. List only	pplications that caused the death. Do one cause on each line.	not enter the mode of	dying, such as			rrest.		
sician edical miner	niner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	one cause on each line.	of):				rrest.		Interval Between Onset and Deat
hysicien and the burial-transit	edical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence	ymphmoon:				rrest.		Interval Between Onset and Dear
ittending physicien and cuse as the burial-transit	icai	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a consequence b. Due to (or as a consequence	ymphmoof): of): of):	ancy		respiratory a	23	dd. Date of deli Month	Interval Batwee Onset and Deat MOVIES Avery Day Yea
gned by the attending physicien and undoughed for use as the burial-transit and undoughed for use as the burial-transit undoug	by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	Due to (or as a consequence b	of): of): of): h 3 Ectopic pregning 5 Other (specify)	ancy	s cardiac or	respiratory a	23	Month e contribute to	Interval Betwee Onset and Dea Conset
has been signed by the attending physicien and under the burial-transit	by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequence d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 9 Unknown	of): of): of): h 3 Ectopic pregning 5 Other (specify)	ancy	s cardiac or	23e. Did	23 tobacco us Yes 2	Month e contribute to No 3 Pre 24b. Were au prior to death?	Interval Betwee Onset and Deat Month of the Cause of deat obably 4 Unkutopsy findings available.
ate has been signed by the attending physicien and und page 2 should be detached for use as the burial-transit	Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	Due to (or as a consequence b	of): of): of): h 3 Ectopic pregning 5 Other (specify) in the underlying cause	ancy y) e given in Part	s cardiac or	23e. Did 1 □ 24a. Was auto perf 1 □ Yes (Check only)	tobacco us Yes 2 s an ppsy ormed? 2 No one)	Month e contribute to So 3 \(\text{Pr} \) 24b. Were au prior to c death? 1 \(\text{Yes} \)	interval Between Onset and Deat Month of the Cause of deat obably 4 Unkind obably 4 Unkind obably 4 Unkind obably 4 Completion of cause 2 No
is certificate has been signed by the attending physicien and undertor, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence b. Due to (or as a consequence c. Due to (or as a consequence d. Due to (or as a consequence d. Please birth 2 Fetal death 4 Pregnant at time of death 9 Unknown contributing to death but not resulting	of): of): of): h 3 Ectopic pregning 5 Other (specify) in the underlying cause	e given in Part 26. Plac Other: 4 N	I.	23e. Did 1 □ 24a. Was auto perf 1 □ Yes (Check only)	tobacco us Yes 2 s an ppsy ormed? 2 No one) idence 6	Month e contribute to fo 3 Pri 24b. Were au prior to death? 1 Yes	Interval Between Onset and Deat Manual Conset
After this certificate has been signed by the attending physicien and upper tuneral director, page 2 should be detached for use as the burial-transit of the contract of the c	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 no 9 unknown Part II. Other significant conditions Lung Cancul Demantion 25. Was case referred to medical examiner? 1 yes 2 No 27. Manner of Death 1 Natural 5 Pending	Due to (or as a consequence b	of): of): of): of): h 3 Ectopic pregning to the underlying cause to the	ancy y) e given in Part	I. Ce of Death Hursing Hom	23e. Did 1	tobacco us Yes 2 s an ppsy ormed? 2 No one) idence 6	Month e contribute to fo 3 Pri 24b. Were au prior to death? 1 Yes	interval Between Onset and Deat Month of the Cause of deat obably 4 Unkind obably 4 Unkind obably 4 Unkind obably 4 Completion of cause 2 No
After this certificate has been signed by the attending physicien and upper tuneral director, page 2 should be detached for use as the burial-transit of the contract of the c	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence b	of): of): of): of): h 3 Ectopic pregnation of the state of the s	26. Plac Other: 4 \(\text{N} \) Injury at Work? 1 \(\text{Yes} \) 2 [ffice	I. ce of Death Nursing Hom 2	23e. Did 1 24a. Was auto performed to the control of the control	tobacco us Yes 2 s an ppsy ormed? 2 No one) idence 6 how injury (Street and own, State)	Month e contribute to No 3 Pro 24b. Were au prior to death? 1 Yes Courred	interval Between Onset and Deat Manual Plant Pla
Eunerel Director: After this certificate has been signed by the attending physicien and U.S. ely filled in by the funeral director, page 2 should be detached for use as the burial-transit of D.S. ely filled in by the funeral director, page 2 should be detached for use as the burial-transit of D.S. ely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence b	of): of): of): of): h 3 Ectopic pregning to the state of the sta	e given in Part 26. Plac Other: 4 N Injury at Work? 1 Yes 2 I	ce of Death Nursing Hom	23e. Did 1 24a. Was autour 1 Yes (Check only ne 5 Res 8d. Describe 18f. Location City or To	tobacco us Yes 2 s an spsy ormed? 2 No one) idence 5 how injury (Street and wn, State) a cause(s) a	Month e contribute to No 3 pri 24b. Were au prior to death? 1 Ves Souther (Special Control Number or Ri and manner as	Interval Between Onset and Deat Onset and Deat Market Programmer of the cause of deat obably 4 Unknown of the cause
Eunerel Director: After this certificate has been signed by the attending physicien and U.S. ely filled in by the funeral director, page 2 should be detached for use as the burial-transit of D.S. ely filled in by the funeral director, page 2 should be detached for use as the burial-transit of D.S. ely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions LWG Cancul Demontor 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 1 Yes 2 Yes 2 Yes 1 Yes 2 Yes 1 Yes 2 Yes 2	Due to (or as a consequence b	of): of): of): of): h 3 Ectopic pregnation of state of the state	26. Place Other: 4 N Injury at Work? 1 Yes 2 Iffice	ce of Death Nursing Hom 2: No 2 and place, a eath occurre	23e. Did 1 24a. War autour perf 1 Yes (Check only the 5 Res 8d. Describe Ref. Location City or To	tobacco us Yes 2 san ppsy ormad? 2 No one) idence S how injury (Street and wm, State) e cause(s) i, date and	Month e contribute to No 3 Pri 24b. Were au prior to c death? 1 Yes Contribute to It was a contribute to A contribute t	Interval Between Onset and Death Death Onset and Death Death Death Death Death Death Death Dea
Urbitector: After this certificate has been signed by the attending physicien and Urbitector, page 2 should be detached for use as the burial-transit Urbitector.	edical Certification: To Be Completed by Physician/Medical	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence b	of): of): of): of): h 3 Ectopic pregnation of state of the state	26. Place Other: 4 N Injury at Work? 1 Yes 2 Iffice	ce of Death Nursing Hom 2: No 2 and place, a eath occurre	23e. Did 1 24a. War autour perf 1 Yes (Check only the 5 Res 8d. Describe Ref. Location City or To	tobacco us Yes 2 san ppsy ormad? 2 No one) idence S how injury (Street and wm, State) e cause(s) i, date and	Month e contribute to No 3 Pri 24b. Were au prior to c death? 1 Yes Contribute to It was a contribute to A contribute t	Interval Batwee Onset and Deat Manual Policy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death Month 2008 January 16, 4b. City, Town, or Location of Death 4c. County of Death Montgomery 01nev If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 1 □ M 2 🙀 F 82 1926 North Jan. 14,

1. Decedent's Name (First, Middle, Last) **Physician** Madge Fender Rich 23:35 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery General Hospital Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** ["]Carolina Director <u>530-20-8627</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's United States 20874 13919 Bromfield Road within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I □ Yes 2 ☑ No f Yes, Give /ear or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White ģ 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "ne any injury or other traumatic event, the Medicone. United States Air Elementary/Secondary (0-12) College (1-4or 5+) Payroll Clerk Force Reserves 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joshua A. Fender Lela Black 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13919 Bromfield Road, Germantown, MD 20874 Gary A. Rich / Son 20b. Place of Disposition (Name of cerutetry, grematory or other place)
Maryland Veterans
Cemetery at Cheltenham Jan. 29, 2008
Cheltenham, Maryland 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liq Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease shock, or heart failure. pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1260 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to loras a consequence of): Examiner law requires that the death certificate be executed ouas burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed page 1□ Yes 2 No Hospital or Attending Physician: director Be

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 20 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

(Check only one)

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

INCE

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

🌠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAS

6 ☐ Could not be

State Registrar

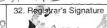
ျှ

Certification:

Medical

this After this funeral c

31. Date filed (Month, Day, Year)



and manner stated

08-00041 **Curtis Summers**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1-For Statemend #2 Per Phy G875 1/204008cattle of Death Reg. No 2. Date of Death 2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1546 hrs January 2, 2007 Medical Examiner Curtis Summers 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore St. Agnes Hosptial 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 5. Social Security Numberink 7. Age (In yrs. last birthday) 6. Sex **Funeral** Foreign Country North Months Days Hours 1959 Nov 10, Director 48 1 X M 2 Yrs arolina Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. Count Yes 2 No 28a-f show Baltimore MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Numbe 21229 USA 3629 Gelston Drive 14. Race - American Indian, Black, Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 XNever Married 2 Married 2 X No Yes è Specify: black Yes 2 X No specify: 4 Divorced If Yes. Give Year 'natural", ģ 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Defiliation of the permit Pages 1 and 2 should be filed within 72 hours: openit. Pages 1 and 2 should be filed within 72 hours: Important: If item 27 is marked other than "maturi winery or other traumatic event, the Medical Exami 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 construction laborer 0 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Minnie Timmons Curtis Summers Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3629 Gelston Drive Baltimore, MDLinda Summers/sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Removal from State Burial 2 Cremation 3 Donation 5 X Other Specify: in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street uner Service Licensee Signature of Funer rector MD Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. Mad Ct Death a. Heroin and alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical XUNPENDED AMENDED #23a. signed by the attending physician | | be detached for use as the burial -27. 28a-f perMF 9875 1/31/08 TT Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnat 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available After this certificate has been a funeral director, page 2 should 24a Was an prior to completion of cause of autopsy performed? death? 2 No Yes 2 1 🗸 Yes 26.Place of Death (Check only one) the Hospital or Attending Physician: thin 24 hours after death. The Funeral Director: After this certifi-upletely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be Other-Hospital: Inpatient 2 V ER/Outpatient 3 Nursina Home 5 Other ٩ 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: Natural Yes 2 XNo Pending Fnd 1/2/2008 Fnd 3:00 pm unk 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3629 Gelston Dr. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide within 24 hours at To the Funeral L determined (Specify) other-scene 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wedical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 21 and manner stated, 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie January 3, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 11/1 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registra OCME

Funeral Director show r than "natural" or items 23a or 28a-f show the Medical Examiner must be notified at Saltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If them 27 Is marked other th **Physician** /Medical Examiner attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760,

1- State Registrar Amend 17&18, perFh,g875, 1/22/08 TICertificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Khanom Month Day **Physician** Khanon Babazadeh SENEHI 19, 2008 10:30 A Kharion Babazadeh Senehi January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8110 Whittier Boulevard Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 💢 F Yrs. 95 Iran 578-02-3560 Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No Maryland Montgomery Bethesda Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20817 United States 8110 Whittier Boulevard by Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Specify: white 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Begonjohn Daniel Asher Babazadeh Begomjohn Daniel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8110 Whittier Boulevard, Bethesda, MD 20817 Manoutch Senehi, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition M☐ Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Capitol Heights, MD Kesher Israel Cemetery 01/21/08 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Furieral Service Licensee 254 Carroll St., NW, Washington, DC shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Due to (or as a consequence of): Respiratory Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☑ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Unknown Urinary Tract Infection Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Do034505 mitmas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14800 Physicians Lane, Suite 132, Rockville, MD 20850 M.D., Maryam Mizrahi, 31. Date filed (Month, Day, Year) 32. Registrar's Signature IAN 2 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #1, per/ID, #18 per/Fh, C3/6, 2/12/08 TT State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 6:09 P /Medical Mollie SOLOMON 17 2008 January 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville 6111 Montrose Road #206 Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 87 Months Davs Hours Min 1 □ M 2 🖫 F 167-16-8686 Director Aug. 9, 1920 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐√es 2 ☐ No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 6111 Montrose Road #206 20852 Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Publishing Company permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 Is marked other: any injury or other traumatic event ** 18. Mother's Name (First Middle, Maiden Surname) Hattie (unknown) 17. Father's Name (First, Middle, Last) Be Isadore Goldman ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8662 Thouron Avenue, Philadelphia, PA Rhonna Solomon, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Nemoval from State Shalom Memorial Park 01/20/08 Lower Moreland, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Years Immediate Cause (Final Arteriosclerotic Heart Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 10 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Diabetes Due to (or as a consequence of) Examiner certificate be executed the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, iding physician Physician/Medical as 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) 29a. Certifier Medical (Check only nd manner stated. 29d. Date signed (Month, Day, Yea January 18, 2008 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

And South

M.D.,

Danilo Molieri,

31. Date filed (Month, Day, Year)

D 52382

4701 Randolph Road, Suite 216, Rockville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ethel M. Silsley Jan 18 2008 0940a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chesapeake Hospital Belair Harford 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month. Dav 9. Birthplace (State or Foreign 6 Sex **Funeral** ^{Year}2,1928 Days Min 217-24-6956 1 □ M 2 X F March 79 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at MD Harford Belair 1 ☐ Yes 2X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sun Flower Drive 21014 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ZNo Specify: White 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen J. Thomas Lillian Rode 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Knight /daughter 391 Church Street Fox Run Glen Rock PA 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 1/21/08 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave.Balto. MD 21. Signature Funeral Service Licensee Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): distress **Physician** /Medical Examiner Severe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Circhosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑ No 24a Was an this certificate has autopsy performed? Yes 2 10 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 000063420 werry 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m. D. 500 upper Chesapeake Dr. Bel Air, mo 21014 Lubair 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Moseph

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:500 Alvear Marie Smith 16 Jan 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Ivy Hall Nursing Center Baltimore Middle River If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 219-12-5507 83 Director Aug. 18, 1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 □Yes 2 □No MD Director Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 304 Patuxent Avenue 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Examiner 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 ö 1 ☐ Yes 2X No Specify: þ Specify: White 3€ Widowed 4 Divorced "natural" Completed er than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Clinton Albert Welling Eleanor T. Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Talley /daughter 1029 Debbie Avenue Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/21/08 Bayview Crematory Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final Physician disease or condition resulting in death) /Medical AUDENT Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Exami physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wiknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy perform 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death.

Ineral Director: After this y filled in by the funeral di 27. Manner Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) 1 Matural 2 Accident 5 Pending investigation 1 Tyes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🧘 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 8:32 P M 19, January Charles William Springer 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 87 159-16-8895 03/25/1920 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show a notified at show 1 ☐ Yes 2X No Baltimore Director MD Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 21234 2612 Wycliffe Road USA permit. Pages 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) S.T.A.-I.L.A. Elementary/Secondary (0-12) College (1-4or 5+) Konoshoremen's Pension 12 Co-Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dennis Ross Springer Jennie M. Brownfield ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2612 Wycliffe Rd. Parkville, MD. 21234 Mary L. Springer/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place. Date 20c. Location - City or Town, State 20a. Method of Disposition Moreland Memorial 01/23/08 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkville, 4 Donation 5 Dother (Specify) Park 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services
8800 Harford Rd. Parkville, MD. 21234 21. Signature of Funeral Service Licensee 2 a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest s bok, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ardiovasculai Immeriate Cause (Final disease or condition cars **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine burial-transit physician and Due to (or as a consequence of): Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autop performed 212 No certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence Other (Specify) 1 ☐ Yes 2 ◯ No 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 ☐ Pending investigation Natural Accident Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be exec within 24 hours after death To the Funeral Director: . completely filled in by the f

1241

State Registrar

Medical

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltono 21204 1 ouscutown KNPMD 555 W.

29b. Signature and title of certifier

(Check only one)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 07:00 A^M 01/18/2008 Michael W. Stein /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Health and Rehabilitation Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 MM 2 □ F 91 03-06-1916 MD Director 213-03-1311 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatih and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1638 Furnace Drive 21060 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No white Specify 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael D. Stein Ethel Sweeney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 Is any injury or other trau Mrs. Mariette Stein / wife 1638 Furnace Drive; Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Crematjon 3 ☐Removal from State Maryland Vets. Cem. 4 ☐ Donation 5 Other (Specify) 01-22-2008 Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation eral ervice Licensee 21. Signature Services; 1 2nd Ave SW; Glen Burnie, MD 21061 23a. Part1. Entertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) /Medical Due to (or as a conseque **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit rena Due to (or as a consequence of) Hypothypoidion Physician/Medical as the l attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Day for Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy performed? Yes 2**X** No certificate 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 20 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After: Injury (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Division or Vital Records, P.O. Box 68760, or Attending

To the Hospital or Attendi within 24 hours all er death. To the Funeral Director A completely filled in by the fu

State Registrar

Medical

nsistym

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mallion Park Drive State 16 Glan Burnie MD 21201 MO 1411

32. Registrar's Signature

6 Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 17, 2008 8:45 P M Richard Carlton Strittmater /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore <u>Stella Maris</u> Timonium 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⋉**M 2□F 160-16-1815 Yrs. 84 Director Aug. 26, PA 1923 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo **Funeral Director** Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? nt of Health and Mental Hygiene.
If flem 27 is marked other than "natural", or Items 23a or or other traumatic event, the Medical Examiner must be a 21014 602 Churchill Road Condo G USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No WWII
If Yes, Give
Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🛣 No White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Goverment Physicist Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in ment of Health and Mental ant: If Item 27 is marked o Catherine Strittmater Unknown Unknown P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Churchill Road Condo G, Bel Air, MD 21014 Katherine Strittmater (wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 1/21/2008 Forest Hill, MD. Centre Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Road. Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of thing, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on activing.

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 150,500 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Hospital: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29c. License number 29d. Date signed (Month, Day, Year) -08 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

DR. EDDIE NAKHUDA

31. Date filed (Month, Day, Year)

RICHARD

32 Registrar's Signature

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** August W. Schulz 11:55A M 2008 January 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest Care Center If Under 1 Year if Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months New Jersey 1**X**XM 2□ F 147-09-2650 95 2/13/1912 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21234 8810 Walther Blvd. Apt # 1106 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Bulidings Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Catherine Reis Schulz August 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8810 Walther Blvd. Apt. # 1106 Parkville, MD 21234 Evelyn L. Schulz / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If It any injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/2008 Towson, Maryland Hilltop Serv. Corp. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. al Between Onset and Death immediate Cause (Final Physician disease or condition resulting in death) /Medical nas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division or Vital Records,

death with the Marylan

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Ite

Item 27 Is marked other than "natu other traumatic event, the Medical

Baltimore, Maryland 21215-0036

28a-f shov

ıral", or Items 23a or 28a-f shov Examiner must be notified at

attending physician and for use as the burial-trai ned by detacl has s certificate has lirector, page 2 director, this After

Medical

State

n 24 hours after death.

he Funeral Director: A
pletely filled in by the fu

within 24 To the F Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

29c. License number

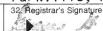
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

2008

8800 Walther Blvd. Parkville, Maryland 21234

31. Date filed (Month, Day, Year) JAN 2 2





Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:40 A. M 16, 2008 January Dorothy Joan Streeks **/Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Collingswood Nursing Home Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 F 91 Aug. 24, 1916 England 212-36-9506 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 299 Hurley Avenue 20850 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Q White 3 XWidowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene important; if item 27 is marked other than any Injury or other trainmetic. Elementary/Secondary (0-12) College (1-4or 5+) Public School System Library Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leslie Steedman Amy Neale ပ 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) ~2000819a. Informant's Name/Relationship (Type. Print) 2700 Connecticut Ave., N.W., #508, Washington, D.C. Richard Paul Streeks / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 22, 2008 Rockville, Maryland Parklawn Memorial Park 4 Donation 5 Other (Ş 21. Signature of Funeral Ser Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of Examiner Varice if any, leading to immediate cause. Enter Underlying Cause (Disease or injury eque yfigilly list condition Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an certificate has perform 2 No Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendli within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide i 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medica 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Sass Month **Physician** J Floyd Toney /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Himore roton 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F Months Director 212-26-2510 Sept9,1930 S.C Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 1 XYes 2 No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be nonce. 900 Allendale St. 21229 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 2vears Supervisor VeteransAdministrat. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Prince Toney Theola China 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Toney-McCrae/daughter846 Market St. Patterson, N.J. 07513 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) GreenmountCrematoryJan.22,2008Balto. MD Name and Address of Facility 21. Signature of Funeral Se vice License S. SCRUGGS FUNERAL HOME PRESTON ST. BALTIMORE, MD21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** marth 104/9 /Medical Due to (or as a o nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the hirria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4□Pregnant at time of death 1 ☐ Yes 2 ■ No been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an page 2 s autopsy performed 2 No or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifict completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital [KertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examiner and manner stated. fination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

POTA

Bultimore, 40 2017

0.0

1.0

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

·W

Jonathan

31. Date filed (Month, Day, Year)

Vital Records, P.O. DONALD TAYLOR

2008

JANUARY

Division or death. To the Hospital or Attenct within 24 hours after death To the Funeral Director:

12

State Registrar

4 THomicide

29b. Signature and title of certifier

29a, Certifier (Check only

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. CAN 2

DR. EDDIE NAKHUDA

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year John Henry Tibbs January 18, 2008 5:18 /Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 203 Hammershire Rd. Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 6, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XXM 2□F 226-46-8674 68 1939 Virginia **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes XXNo MD Baltimore Funeral Director Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 203 Hammershire Rd. 21136 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must. once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Æ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □ Yes X2X No Baltimore, Maryland 21215-0036 Specify: Specify: **Black** Completed by XXWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MD Speciality Wire Tow Motor Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Grayson Mary E. Thomas ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Marie Tibbs / Daughter 203 Hammershire Rd. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Gough Cemetery 1/25/08 Cockeysville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Juneral Service Licens 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a ensequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine / Le that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the atter 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic dosmitues lung diseuse Celeboursals disease 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an Squmus cele CEVULNIVE autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DOA 27. Manner of Death 1 Devatural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death.

I Director: After this continued in by the funeral director. within 24 hours a To the Funeral C

10

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year)

29b. Signature and

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) DR. HARRY KAPLAN WAS W.

title of certifier

2

4000

A. Subsul

CLD COUNT PUD 32. Registrar's Signature

Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

04037

29d. Date signed (Month, Day, Year)

1/21/08

Antinave, MO 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year January 14, A M Putlamai Tengra 12:05 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral Date of Birth (Month, Day. 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 🛈 F 1922 Pakistan Director 85 217-96-0081 December Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Germantown 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be r 12912 Pickering Drive 20874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be Poonegar Rustumji Bharucha Maneckbai 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, Zarine Ranji- daughter 12912 Pickering Drive, Germantown, Maryland 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Jan. 18,2008 Alexandria, Virginia 22. Name and Address of Facility
Fleck Funeral Home, INC. 21. Signature of Euneral Service Licensee 0123 7601 Sandy Spring Road, Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Cancer Left Lung resulting in death) /Medical Due to (or as a consequence of): Examiner Upper G.I. Bleeding Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-transit Cachexia that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician for use as the buria Physician/Medical Sever Protein Calorie Malnutrition IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ been siç Respiratory Failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autonsy perform Division or Vital 1 ☐ Yes 2 ☐ No 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ٩ this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation spital or Attendiours after death.
neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kirti Vohra MD 7710 Bradley Blvd, Bethesda, Maryland 20817

32. Reģistrar's Signature

29c. License number

D20274

29d. Date signed (Month, Day, Year)

January 14, 2008

Registrar

State

H. Robert Birschbach,

31. Date filed (Month, Day, Year)

201 Russell

M.D.,

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dafna Koldobskiy

JAN 2 2 2008

Koldolski 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UMME

32. Registrar's Signature

17436

MD

22 S. Greene St

Baltmore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 17, 2008 **Physician** January 4:45 A M George R. Toney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4915 Redford Road Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year)
June 26, 1918 Rhode Island Social Security Number **Funeral** Months Days Hours 1XM 2□F 89 010-14-7952 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 20816 USA 4915 Redford Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1941-45 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced ed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Complet and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Administrator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Robert Toney Winifred Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s.
Department of Health an
Important: If item 27 is 1
any Injury or other traut 4915 Redford Road Bethesda, MD 20816 <u>Sara D. Toney/wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory: 01/19/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service I Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** a. Lung Cancer 4 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the Ses IF FEMALE: nse If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Emphysema icate has been sig 7, page 2 should b 11 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ne Hospital or Atte.. n 24 hours after death. neral Director: After...he fur Certification: 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

2011

Registrar

29b. Signature and title of ce

Hamm, M.D.

31. Date filed (Month, Day, Year)

29c. License number

Wisconsin Avenue Suite 930 Chevy Chase, MD 20815

D32033

29d. Date signed (Month, Day, Year)

January 18, 2008

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>5530</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 3875 1-22-08 Whealth and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Arnetta **Thomas** Month **Physician** 5:35 PM BOOR January. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner baltimore OF BALTIMORS Mospital Sirai If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 □ M 2 💢 F Vrs 29,1960 MD JULY Director 220 76 1414 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a. State 10b. County show r 28a-f show notified at 1 ▼Yes 2 No N/A BALTIMORE MD. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21218 USA th and Mental 'ygiene.
7 Is marked other than "natural" or items 23a or traumatic event, the Medical Examiner must be a 120 MONTPELIER ST. death v Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: iled within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2√ No Baltimore, Maryland 21215-0036 Specif BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) LEWIS ADVERTISEMENT MAIL HANDLER llth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be CLARA THOMAS THOMAS PETERSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1120 MONTEPLIER ST. BALTO, MD. 21218 FLEET C.DARBY, JR (husband) Department of Health a Important; if item 27 Is any injury or other tra Health a 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State MT.ZION CEMETERY JAN. 25, 2008 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign and of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME NUGGA 1412 E PRESTON ST. BALTO, MD. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lena Oyoacs Physician disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner 4Qars Karsetes Scarning list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician pe Physician/Medical the as 1 Jse 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year Month Day for 5 Other (specify) 1 ☐ Yes 2 DNo ed by the a detached (9□Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Intrabdom na After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2010 2 No 1 Yes Wath. Severe Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 ☐ Pending investigation n 24 hours after death.
the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 85-000 2008. January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE ROBBS-CALDERON 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 250K

DHMH 17 Rev 1/2001

Registrar

JONE 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Williams 18 2008 Ja /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA Baltamore medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)

Q Yrs. 9. Birthplace (State or Foreign **Funeral** 1ÀM 2□ F 34-410 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: if item 27 Is marked other than "natural", or items 23i ury or other traunraite event, the Merical Examiner must ury or other traunraite event, the Merical Examiner must by Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 风Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OOK BENEZEK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILL injury or other Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location City or Town, Stat permit. Page Department o Important: if i 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE, M.D 1ETRO 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner MRSA bacteremi Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year signed by the at 5 Other (specify) Division or Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by heart failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? res 242 No certificate 1∏ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dli this 28a. Date of Injury (Month, Day 27. Manper of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

Jia 31. Date filed (Month, Day, Year)

Chan

10 N. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street Greene

M.D.

18134

Balaimore

MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend 9, 11,12,15,16a-b,17,18,19a-b,7/a-(22,perFH,3/2, 1/28/08 TT Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Walters Physician KVIN JANUARY 12TH 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bultimore Bossecous HUSP: tal If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 M 2 □ F unk 214-26-3314 Jan 16, 1926 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1√ Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3211 Brighton Street 21216 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U. Sunk:
Armed Forces?

1 □ Yes 2 ▼ No
If Yes, Give
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1□ Yes 2 ▼ No Specify: Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married "natural", or Baltimore, Maryland 21215-0036 Specify: black ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 1111/c (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Longshoreman Maritime 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be and Mental I and 2 should be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Edna Ringgold James Hollie ပ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Cards) 195 Dermore Avenue, 21215 2000 W. Baltimore Street Baltimore, MD 2122 19a Informant's Name (Belationspip (Type. Print)

Ms. twelyn Moss (great niece)

Bon-Secours-Hospital 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【**XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ② Other (Specify) in State Jan. 28, 2008 Baltimore, MD Greenmount Crematory state SE Name and Autors (Fanny Russ 451. 7222 W. North Avernet 21. Signature of Euneral Single Licensee Ronal Single Ware Dire Director Baltimore, MD 21201 21216 inn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial in farction **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any being to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Physician/Medical Examiner the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, aftending physician the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2: autopsy performed? 2 40 Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DOA 20 No Certification: To 1 Tyes 1 Inpatient funeral 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier Low Roberton, MD Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 WW/ Dullimone State to Baltinunc 21201 31. Date filed (Month, Day, Year)

JAN 2 2 32. Registrar's Signature Grant 1 State 2008 1480 Registrar

08-00268

Me

Dian

Brint in Black Indelible Ink. Ensure All Copies Are Legible.

9266	Type or Print in Black In	delible Ink.	Ensure All Copies Are L
Casc	State of Maryland / Depa	artment of He	ealth and Mental Hygiene
		wificate of Do	

ne Delores W	1	1- F	or State	St	ate of	Maryla	nd / [Depart <i>Certi</i>	tment c ificate c	of Health of Death	and ivie		Re	g. N o	201	9 C	1115
Physicia		1. E	istrar Decedent's Nam	e (First, Midd	le,Last)							1	2. Date of Death Month January 9,	Day	Year	1700 hrs	1
dical Exami	ner		Diane	Delo	res	Willi	ams			4h City To	vn, or Location	on of Death	January 9,	4c.	County of Death		
			Facility Name (if not institution	on, give s	treet and nur	nber)			Baltimo		011 01 2 0 0 11					
			5837 Arizor		6. Sex		7. Age (In vrs. las	st birthday)	If Under	1 Year If U	inder 24Hrs.	8. Date of Bir	h(MM/l	DD/YYYY) 9. Birt Foreig	hplace (State	or
Funeral Director			Social Security 1 12-42-3			1 2X F		64		Months 'rs.	Days Ho	ours Min.	04/06/	194	_	untry) MI)
any		_	ual Residence d a. State	Decedent 10b. County			10	0c. City, 7	Town or Loc	ation						10d. Inside C	
* .	_		MD						Bal	timore				On City	zen of What Cou		
Aarylar 28a-f s d at ou	Director	10	e. Street and No	umber						10f. Zip (og. Ora		,	
h the N 3a or otifie		L	5837 A	rizona	Ave	12. Was Dec	adopt E	vor in II S	S 113 1	Was Deceder	21206 t of Hispanic	Origin? (Sp	ecify Yes or No)-	USA 14. Race - Amer	ican Indian, B	lack,
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. The true and a statural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at ouce.	Funeral	11	. Marital Status Never Mari	ried 2		Armed F	orces?	X No	. 10.	If Yes, specify	Cuban, Mexi	ican, Puerto	Rican, etc.)		White, etc.		
ter de ", or i er mu	l F	3	Widowed	4 XD	ivorced	If Yes, Give Yes				Yes 2				11Ch	Specify: W Kind of Business	hite	
nurs af Iturali amin	d by	Ή,	5. Decedent's I	Education (Sp	ecify on				16a. Dece durin	dent's Usual (g most of wor	occupation (Ging life, DO I	Give kind of v NOT use reti	vork done red)	160.	Kind or business.	modott y	
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The man 27 is marked other than "natural", in mortant. If item 27 is marked other than "natural", in my or other tranmatic event, the Medical Examiner.	Completed		Elementary/Se		2)	College (1-4 or 5-	+)	А	ssembl	v				Factory		
003(within iene. cr the	ᇤ	L	7. Father's Nam	6	lo Last)						18. M d	other's Name	e (First, Middle,	Maide	n Surname)		
15-(filed if Hyg if Hyg ed oth	Be C		Joseph									Gen	nevieve	J	Bytella		
21215-0036 21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than ie event, the Medica	B O	19	Joseph Pa. Informant's I	Name/Relatio	nship (T)	pe, Print)			ı						City or Town, Sta		
MD d 2 shot lith and m 27 is aumatic	1		Jean A.	Brown	1	Si	ster		604	Stone sposition (Nar	Barn	Road,	Towson Date	, <u>M</u>	D 21286 :. Location - City	or Town, State	:
e, F. I and Healt Fitem	1		Da. Method of D	isposition X Cremat	ion 3	Removal	from Sta		crematory of	sposition (Nat or other place	le of certiere	l l					
nor Pages ent of nrt: If	1			5 Other				Ca	rrol1	Crema	tion		16/08		Hampste		
Baltimore, permit Pages I at Department of He Important: If ite		3	1. Signature of	Funeral Serv	ice Licen	see	15.05			22. Name and Eline				4 R	eisterst stown, M	.own Ro	ad 6
	_	P	3a. Part I. Enter	0		mu lications that	caused	the death	n. Do not er	ter the mode	of dying, such	h as cardiac	or respiratory a	rrest, s	hock, or heart	Approxim	nate Interval
Physician		2	3a. Part I. Enter failure. List	only one cau													Death
amine		1	mmediate Caus	e (Final disea	ase a.	Contact C	a conse	equence (of):	au							
					b.	200 (0 (0)										-	
	<u>ة</u>	5 i	Sequentially list f any, leading to cause. Enter U	immediate		Due to (or as	a cons	equence	of):								
	Evamin		Disease or inju events resulting	ry that initiate	ed of	Due to (or as	a cons	equence	of):								
nted d			events resulting	illi death) Le	d.												
executed	leaile us	2	UNPEND	ED		AMENDE	D							_	23d. Date of deli	verv	
OX 68760, cath certificate be executed attending physician and	me ou		F FEMALE: 3b. Was deced	ont pregnant	in the			me of pre		Fetal deat	3 🗔	Ectopic preg	nancy		Month	Day	Year
687 certific	se as i		past 12 mo		iii uic		e birth egnant a	t time of o	death 5	Other (Sp							
Box 68760 death certificate l	Tor u	Physician/Me		No 9 🗸		0 0	known					. Deal	230 D	id toba	cco use contribute	e to the cause	of death?
O. But the delay the			Part II. Other s	ignificant co	nditions	contributin	g to dea	th but not	t resulting it	the underlyi	ig cause giv€	en in Part I.			2 No 3		
, P.C ires that	be de	9													1 24h Wer	e autonsy find	ings availabl
rds requi	should	흥											a	utopsy erforme	prio	r to completion	of cause of
e law te has	ge 2 s	Completed by				_							1 🗸 Y	es 2		Yes	2 No
of Vital Rec ing Physician: The After this certificate	tor, pa		25. Was case i	referred to me	edical						100	f Death (Che			esidence 6 🗸 (Other: Scene	
Vita ysicia this ce	direc	을 일	examiner?	2 No		Hospital: 1		tient 2	_'	patient 3	DOA 28c. Injury		rsing Home 5	ibe hov	w injury occurred	741011 00011	
of 'ng Ph	uneral	اء'	27. Manner of			28a. D	ate of Ir onth, Day ND:	njury _/ ,Year)	FOUN	me of Injury ID:	1	s 2 V No	Subject	shot s	self		
ion tendii eath.	the fi	읉	1 Natura 2 Accide		Pending Investiga	. lan	2008	l .	1705				28f. Locati	on (Str	eet and Number	or Rural Route	Number, Cit
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the agree death.	l in by	Certification:	3 V Suicid	e 6	Could no	ot be				II, Street, ract	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or Tox	en Cto	te) venue , Baltimo		
Division Hospital or Attend 24 hours after death.	/ filled	င်	4 Homic			1 (-/		my know		h occurred at	the time, date	e and place,	and due to the	cause(s) and manner as	s stated.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate lawitin 24 hours after death.			(Check only	Certifyl Medica	ng Phys I Examir	er:On the ba	isis of ex	xaminatio	n and/or in	vestigation, in	my opinion,	death occurr	red at the time,				(S)
To the within To the	com	Medical	29b. Signature			and man	er state	:u			29c. License				29d. Date signed	(Month, Day,	, Year)
		-	Dri			**	P	00	L		O.C.N	Λ.E.			January 10,	2008	
\prec			30. Name and	address of p	erson wh	no completed	cause c	of death (I	Item 23a)	~				4001			
12	3			Aronica-F		MD. As	sistant	Medic	al Exam	ner 111	Penn Str	eet, Baltii	more, MD 2	1201			
		ate					2. Regis	trar's Sig	nature	Anna	E p						
Re	gist	rar		JAN	22	วบับธิเ	Contract of the second	M. Sales	OD	IGÍNAL							
DHMH 17 Re	v 1/20	001							UK	GINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Darlene Marie Wo	ood		te of Maryland /							jibie.		
		1- For State Registrar		Cert	ificate o	f Death			Re	g. No. 2	008.0	116
Physiciar Medical Examin		Montr								Day Year	3. Time of E 1613 h	
Weulcai Examini		Darlene 4a. Facility Name (if not institution,	Marie			Wood 4b. City, Town	n. or Location	of Death	January 17	7, 2008 4c. County o		13
(Johns Hopkins Bayviev				Baltimore				,		
Funeral		Social Security Number	S. Sex 7. Age	e (In yrs. las	st birthday)	if Under 1		er 24Hrs.	8. Date of Birt	h(MM/DD/YYYY)	Birthplace (State Foreign	e or
Director		213-52-1776	1 M 2 X F		58 Yrs		Days Hours	s Min.	Oct. 16	5 1948	CountryMary	land
ý.	Ī	Usual Residence of Decedent 10a. State 10b. County		10c City 7	Town or Locat	tion					10d. Inside	City Limits
d iow any				•								2 No
aryland 8a-f sf at onc	Funeral Director	Maryland Balti 10e. Street and Number	more	Du	ndalk	10f. Zip Cod	de .		10	g. Citizen of Wh	at Country?	X
ilth		6729 Railway A	Venue			2122	22			U.S	٨	
4 with	اع	11. Marital Status	12. Was Decedent	Ever in U.S		as Decedent o	f Hispanic Ori		ecify Yes or No-		- American Indian, E	Зlack,
r death	֟֟֟֟֟֝֟֟֝֟֝֟֡֟	1 Never Married 2 Mar.	1 Yes 2	X No		es, specify Cu			Rican, etc.)			
rs after rral", niner	۾	Widowed 4 XDivor 15. Decedent's Education (Specific	ced If Yes, Give Year	••		Yes 2 X			ork done	Specify: 16b. Kind of Bus	White	
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or 5			nost of working				TOD. KING OF BOX	siness/industry	
036 ithin 7 ne. redica	ᇍ	12	NA		Home	Maker				Own H	ome	
5-0 iled w Hygie fother		17. Father's Name (First, Middle, L			HOME	Hakei	18.Mothe	r's Name	(First, Middle, N	naiden Surname)	,	
21215-0036 Juld be filed within 7 Mental Hygiene marked other than te event, the Medica	Be	William 19a. Informant's Name/Relationshi	John John		Wacht	er		Lzabe		Gertru	de Sande n, State, Zip Code)	rs
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other transmatic event, the Medical Examiner must be notified at once.	٥	Andrew W. Wachte		er)	1						yland 212	22
e, N I and Health item	ı	20a. Method of Disposition		20b. P		sition (Name o		l	Date		City or Town, State	
mor Pages ent of nt: If		Burial 2 XCremation Donation 5 Other Spe			•	remator	т	1 22	uary, 2008	 Baltimo:	re, Maryl	and
Baltimore, permit. Pages 1 ar Department of Hea Important: If ited injury or other tr	ı	21. Signature of Funeral Service L	cens	Day	22.	Name and Add	dress of Facilit	Choi	naoki E	unoral l	Homes P.A	
		23a. Part I. Enter the disease, or co	(Lernai	h.	10	1005 Di	indalk	Ave.	Baltim	ore, Mai	ryland 21	224
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause of	n each lipe.			the mode of dy	ying, such as o	cardiac or	respiratory arre	est, shock, or hea	Between	ate Interval Onset and eath
xaminer		Immediate Cause (Final disease or condition resulting in death)	a. Mor hine in: Due to (or as a conse									
		Sequentially list conditions,	b									
	<u>=</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of)):							
sit id	dical Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of)	:							
executed an and al - transit	<u>8</u>	LINDENDED	d			- 10 10						
60, nte be exe hysician e burial -	ed led	X UNPENDED	#23a 27 28: 23c. If yes, outcom			2/8/C	18 TT			23d. Date of	delivery	
cath certificate be attending physic for use as the bur	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 F	etal death	3 Ectopi	ic pregnar	псу	Month	Day	Year
Box 68760 e death certificate be the attending physical for use as the bu	Physician/Me	1 Yes 2 No 9 V Unkn	own 9 Unknown	time of dea	th 5 0	ther (Specify)				4		
that the detached		Part II. Other significant condition		but not re	sulting in the	underlying cau	use given in P	art I.	23e. Did to	bacco use contri	ibute to the cause of	f death?
res that the signed by be detach	Completed by								1 Yes	2 No 3	Probably 4	Unknown
cords,	e e								24a. Was autop		Were autopsy finding prior to completion of	
Recc The lay	Ē									rmed? d 2 ✔ No 1	death?	No
Vital Rec	Be	25. Was case referred to medical examiner?	Hannital.				Place of Death	(Check c	only one)			
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been si led in by the funeral director, page 2 should been all or the funeral director, page 2 should be a	의	1 ✓ Yes 2 No 27. Manner of Death			ER/Outpatien 28b. Time of		Other Injury at Wor			Residence 6	Other:	
nding Ph. th. : After ti	<u>ë</u>	1 Natural 5 Pendir	28a. Date of Inju (Month, Day,Yo			1		_	unk	low injury occurs	50	
rision r Attencter death irector: n by the	<u>a</u>	2 Accident Investi 3 Suicide 6 Y Could	28e Place of Ini		Fnd 3:2 me, farm, stre				28f. Location (\$		er or Rural Route N	
Division Sepital or Attenct hours after death meral Director: y filled in by the	Certification:	3 Suicide 6 X Could determ		House					6729 Kai	lway Ave.	Dundalk, M)
		29a. Certifier (Check only 1 Certifying Phy	sician: To the best of my	knowledg	e, death occu	rred at the tim	e, date and pl	lace, and	due to the caus	e(s) and manner	as stated.	
To the Hos within 24 h To the Fur completely	Medical		iner:On the basis of exar and manner stated.	nination an	a/or investiga				ine time, date			251
	2	29b. Signature and title of certifier	11 1				cense number	1		January 18	ed <i>(Month, Day,</i> Yea 3. 2008	ar)
	-	Tama Toutha 30. Name and apparess of person w	W. MO	eath (Itom 1	23a)					L. Tournary 10	, 2000	
NT		Pamela E. Southall, ME				I1 Penn St	reet, Baltir	nore, N	ID 21201			
Sta		31. Date filed (Month, Day, Year)	2002 32. Registrar	's Signatur	ė	smilt			_			
Registr												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND 117-19 11 12 15 16a b 17-20 22 periff C875 1/22 08 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** 2258 Emmitt Walls Janua /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Chover Irince Hospilal If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 ☑ M 2 🗆 F 244-78-2431 58 Sept 19, 1949 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No MD Prince George's Capital Heights Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 715 61st Avenue 20743 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black ρ 3 Widowed 4 Vivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry mk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 11 unk-18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be ပ Emmitt Walls, Sr. Annie Lee Smith 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26 Pitcher St., N. Babylon, NY 11703

001 Hospital Drive Cheverly, MD 20783 19a. Informant's Name/Relationship (Type. Print) **Keith Saunders / Son**Prince George & Hospita Department of Health at Important: If item 27 Is any Injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/26/08 Mt. Olive Cem. 4 Donation 5 Other (Specify) in Mt. Olive, NC 22. Name and Address of Facility Lines A. Morton & Sons F.H. 21. Sig ature Funeral Service Licensee Ronald S. Wad, 21201 1701 Laurens St., Balto., MD 21217 Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) Heart Disea Cardiovascular **Physician** Atheres exertic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: t Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural n 24 hours after death.

ne Funeral Director: Af
oletely filled in by the fu 1 ∏ Yes 2 ∏ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hou To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			Please 1	Type or Prin	t in E	Black li	ndelib	le Ink	Ensur	e All (Copies	Are	Legibl	e.		
			For	State of Ma	arylan					nd Mei	ntal Hy	/giene	000		0.1	1 0 0
10	_	_	1 State Registrar	4)		Ce	ertifica	ite of	Death		Data of D	Reg. No.	201	18	UI	163
3-	Physici	an	1. Decedent's Name (First, Middle, Las Clarence Daws		1 т	r					Date of De Month	Day		ear	3. Time o	14
es Vales	/Medic		4a. Facility Name (If not institution, give		1, 0.	Ι.	4b Cit	v Town o	r Location of I		anuar		200 County of		8:20) A
	Examin	er	Holy Cross Hosp						Spring				ontgo		,	
	Funeral		5. Social Security Number 6. Se	7. Age	e (In yrs.	last birthday	y) If Und	er 1 Year	If Under 24	-	Date of Bi (Month, D	rth		. Birthpla	ice (State	or Foreign
Ю	Director		218-30-8009	ZM 2□F	71	Yrs.	Month	Days	Hours				936 P	Count		nia
	w w		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or I	Location							10	d. Inside C	City Limits
	Maryla f sho led at	ō		257	ٔ و	ilver	Snri	na								s 2⊠No
	28a-	rec	MD Montgome 10e. Street and Number	т у		TIVCI		ip Code				10g. Citi	izen of Wha	at Count	y?	
	h with	Funeral Director	 14804 Harvest Lane	2				20	0905				US	A		
	ems a	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.	S. 13	B. Was Dec	edent of H	lispanic Origir an, Mexican, I	in? (Specif	y Yes or N	0-	14. Race -	Arnerica White, e		
92	or It	y Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ N If Yes, Give	10			2 XX No			,		Specify:			
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medikal Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edi	Year or Dates:		16a Dec	edent's Us	ual Occur	ation			16h Ki	ind of Busin			
5	in 72 in na' r	olete	(Specify only highest grad	de completed)		(Giv	e kind of v	vork done use retire	during most o d)	of working		100.10	ind or busin	1633/11100	13ti y	
212	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Own	er-Op	erato	or			Exx	on Ga	s St	atio	n
	be filed within 72 hours after death with the Marylar tital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)						18. Mother's	's Name (F	irst, Middle	e. Maiden	Surname)			
<u>X</u>		To	Clarence D. We	einel							dred					
Maryland	2 ar ar		19a. Informant's Name/Relationship (7				_		and Number							
	ss 1 and of Health item 27		Jean Elizabeth Wei 20a. Method of Disposition	nel/wire	20h P	lace of Disp			Lane,	Date			cation - Cit	209		
Baltimore,			XXBurial 2 ☐ Cremation 3 ☐		0	ion C	rematory o	r other pla		/23/2			tonsv			
			4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License		1 011				ss of Facility				eral			7)
Ba	permit. Departi Importa any Inj		1 Gr SEn		M007				ott Ave	DOM				0707		A •
2.			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	olications that caused	the death	h. Do not e	nter the m	ode of dyir	ng, such as ca	ardiac or re	espiratory a	arrest,			Approxima Interval Be	ate etween
	Physician		Immediate Cause (Final disease or condition	. Pneu		രത്	a.								Onset and	Death >
1	/Medical Examiner		resulting in death)	Due to (or as			- / -	. (8)	+	110		10	4:		ih	15
	Examme	7	Sequentially list conditions, if any, leading to immediate	b. Chro	m	C) (965	stre	uti		14	7	alse	enge	. 1	2
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Den	a consequ	7,2	χ					~			Ur	5.
,	e executed lan and urial-transit	Exal	resulting in death) Last	C. Due to (or as	a conseq	uence of):									-0	
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	_		d												
89	eath certificate be attending physici for use as the bu	Physician/Medica	IF FEMALE:						-							
ROX	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	I death 3	Ectopic		у				23d. Date o Month		y Day	Year
	at the de by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of d	eath 5	⊙ Other (specity) _								
<u> </u>	res that t igned by be detad		Part II. Other significant conditions co	ontributing to death bu	ut not resi	ulting in the	underlying	cause giv	en in Part I.		23e. Did	tobacco i	use contribu	ute to the	e cause of	death?
Records,	quires n sign	d by									1 🗆	Yes 2	□ No 3	☐ Proba	bly 4	Onknown
ပ္ပ	aw require s been sig	Completed									24a. Wa		24b. We	re autop	sy findings	s available
	sician : The law certificate has t irector, page 2 s	mo									auto perl 1∏ Yes	op <i>s</i> y formed? 2 I No	dea	ath?	pletion of	cause of
Vital	stan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place o	of Death (C						
Ž	Physic this ce	To	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie		ER/Outpati	ent 3∐ l		4 🗆 Nurs	sing Home	5 ☐ Res	sidence	6 ☐Other	(Specify	Hos	PICE
Ž	ding P n. After i funera	ion:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry v Year)	28b. Time Injury	/	28c. Inju			d. Describe	how inju	ry occurred			
Division or	I or Attend after death Director: /	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of init	Inv At ho	nme farm s	M street fact		Yes 2 □ No		Location	/Stroot ar	nd Number	or Rural	Route Nu	mhor
2	after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of inju building, etc	. (Specif	у)	ou cou, raoi	J. J		201		own, State		or marar	riodic rid	mber,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best on hiner: On the basis of	of my kno	wledge, de	ath occurre	ed at the ti	me, date and	l place, and	d due to the	e cause(s) and mann	er as sta	ated.	(-)
	the Ho iin 24 the Fi	Medical	one)	and manner sta						- Occurred	at the time					(S)
	To To	2	29b Signature and title of certifier	2					se number				te signed (i			
)	~		A. Nawa	<i>0</i>			D:::	יכע	0-10+			-	-18	- 0	5	
10)	<	AHMED PAWA	· · · · ·		1 23a) (Type	e, Print)	ail	ners!	bure	gn	10	208	83		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra			1	1			<u>U</u>					
	Registr	ar	JAN 2 2 200	8 Town Dollar	7 5	A STATE										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** 10:00AM January 15 2008 Harry G. Walters /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Howard 7848 Milkshed Place Elkridae 8. Date of Birth (Month, Day, Year) March 5,1927 New Jersey If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1 XM 2 ☐ F Yrs. 80 148-14-6819 Director Usual Residence of Decedent with the Maryland 10d, Inside City Limits 10b. County 10c. City, Town or Location r then "neturel", or items 23a or 28e-f show the Medical Exercit at coust be codified at 10a. State 1 ☐ Yes 2 No Director Elkridge Maryland Howard 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21075 U.S.A. 7848 Milkshed Place death v Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 ⊋Yes 2 □ No If Ŷes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: þ White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk Monsanto Co. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine Belle Harry Walters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 I 7848 Milkshed Place Elkridge, MD 21075 Janice Barry (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☑Removal from State permit. Page Department o Importent: If eny injury or once. Gate of Heaven Cem. 1-18-2008 East Hanover, NJ `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death et and Death Immediate Cause (Final disease or condition resulting in death) Physician erebrovASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ō in the past 12 months? 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. GROVIC OBSTRUCTIVE 1 Yes 2 No 3 Probably 4 DONKNOWN ed bluods Completed RIPHERAL CASCULAR Ha. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy SUFFICIENC 2 100 1 ☐ Yes 2 010 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1 Tes 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? e Hospitel or Attending P 24 hours after death. e Funerel Director: After t Certification: After 1 - atural 5 Pending investigation 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar

29b. Signature and title of certifier

H.M. MACHIRAN

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

TREDUING

720 C MAIDEL

29c. License number

16200

hoice LA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 2. Date of Death 3. Time of Death **Physician** January 18, 2008 4:17 P.M Margaret Ward Wiedenmayer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Brighton Gardens Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🖺 F May 28, Ireland 88 1919 Director 577-56-7989 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number United States 20852 5550 Tuckerman Lane, #442 or items 23a Funeral Race - American Indian Black, White, etc. 12. Wes Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Armed Forces ☐ Yes 2 ☑ No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: δ If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillie Laverty Matthew Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph E. Wiedenmayer, III / son 6416 Kenhowe Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. Jan. 22, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lig Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501 M00896 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Mailur... List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Dementia Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? death? 1 ∐Yes 2 ☐ No 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 | Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification: Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titl January 21, 2008 WW7 D53691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Democracy Blvd., Bethesda, Maryland 20817

State Registrar

DHMH 17 Rev 1/2001

M.D.,

Year)

Ajay Reddy, 31. Date filed (Month, Qay, 6320

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1										
23e. Did tobacco use contribute to the cause of death?											
1 ☐ Yes	2 🗌 No	3 ☐ Probably	4 Honknown								
24a. Was an	24b.	Were autopsy fir	ndings available								

23d. Date of delivery

Month

1:50 PM

Birthplace (State or Foreign Country)

USA

WHITE

COOPER.

Approximate Interval Between Onset and Death

Year

14. Race - American Indian,

Black, White, etc.

ACCOUNTING

Specify:

10d, Inside City Limits

1 □ Yes 2 No

2008

Baltimore

Hospital: 1 Hopatient 2 ER/Outpatient 3 DOA

24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ♣ No

25. Was case referred to medical examiner? 1 Yes 22 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the dead of t 29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

showni, MD

D 65843

29d. Date signed (Month, Day, Year) January, 16, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Abdallah Kafrouni, 5401 Old Court Road, Randallstown, MD 21133

State Registrar

funeral director.

completely filled in by

after death.

within 24 hours a To the Funeral I

Be

မှ

Certification:

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🎧 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 3 . OOAM RAYMOND ZAKOWSKY JANUARY 19 2008 KONALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HARBOR HOSPITA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Aug. 6, 1943 64 Months 1**X**M 2□ F 212-42-2567 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits r 28a-f show notified at 10b. County MD 1 □Yes 2√2 No Howard Elkridge Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 21075 6697 Deep/Run Parkway IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 ☐ Widowed 4 € Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Salesman Auto 12th 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othrany Injury or other traumatic event Be Victor Zakowsky Helen Lutinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald Zakowsky Jr. 38 Maka Court Balto. MD 21220 /son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory //23/08 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 5 ☐ Other (Specify) 4 ☐ Donation 21. Signature of uneral Service Leansee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician NON SMALL METASTATIC CFLL /Medical Due to (or as a consequence of): Examiner -IVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner be executed Due to (or as a consequence of): burial-1 physician a Box 68760. requires that the death certificate as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Ö 9□Unknown م signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an EMPHYSEMA has le 2 autopsy performed? Yes 2 No certificate 1□ Yes or Attending Physiclan: After this certification 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | No 1.☐Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

JAN 22 Registrar

31. Date filed (Month, Day, Year)

HANOVER 100 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAHL

2008

M.D. (PGY-1)

STREET, BALTIMORE, MO 21225

DHMH 17 Rev 1/2001

RES ODOI

JANUARY 19 2008

		-	1 - For State Registrar	Certificate of L	Death	Re	eg. No.2	01168
Н	Physici	an	1. Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Dav Year	3: Time of Death
ķ.	/Medic	al	TAYLOR BURGER ZINN, JR	4h City Town or	Location of Death	JAN	8 2008 4c. County of Dea	6:38 A M
	Examin	er	4a. Facility Name (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER		HESDA		MONTG	
h.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Director		232-05-7638	rs. Months Days				t Virginia
	w		Usual Residence of Decedent 10a, State 10b, County 10c. City, Town	or Location				10d. Inside City Limits
	Maryla	lor		Marlboro				1 ☐ Yes 2 ☑ No
	r 28a-	irec	10e. Street and Number	10f. Zip Code		11	Og. Citizen of What C	ountry?
	th witl 23a o Ist be	al D	7201 Thomas Drive	20772			USA	
	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	rs afte	by F	1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No 1941 — If Yes, Give 1969	1 ☐ Yes 2 🔀 No	Specify:		Specify: W	nite
5-0036	2 hour atural cal Ex		15. Decedent's Education 16a. I	l Decedent's Usual Occupa			16b. Kind of Business	
215	thin 7; e. an "n Medi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done of life. DO NOT use retired) -			
2121	filed wit Hygien rther th	S		rketing Repr			Defense Co	ntractor
Maryland	tal d c	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		*	
⋛	should ind Men s marke umatic	ဥ	Taylor B. Zinn, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street a	Rebecca			Zin Code)
<u>s</u>	and 2 sho ealth and n 27 is ma			201 Thomas D				
ē,			20a. Method of Disposition 20b. Place of cameters	Disposition (Name of y, crematory or other place	; D		20c. Location - City of	
Ë	Page not c int: If			ton National	1	2008 A	rlingten,	Virginia
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Murre of Lineral Service Licensee M00968	22. Name and Addres	Funeral C	hoices	exandria,	22307 Virginia
8	7		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition AORTIC STEN	OSIS				Onset and Death
	/Medical		resulting in death) Due to (or as a consequence or					
10	Examiner-	١,	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence or	.43.				
	pa 11/1	nju	Cause (Disease or injury	17.				
<u>,</u>	n and	Examiner	that initiated events resulting in death) Last	f):				
68760,	ificate be executed a physician and streets the burial-transit	cal	d					
Τ.	rtifica ng ph	Medical	IF FEMALE:					
Box	Attending Physician: The law requires that the death certificate be executed reath. r death. ector; After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	an/I	23b. Was decedent pregnant in the past 12 months?		/		23d. Date of de Month	elivery Day Year
<u>.</u>	ne deg the al	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)				,
Д.	ires that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tol	pacco use contribute t	to the cause of death?
Records,	uires sign ld be	d by				1 □ Ye	es 2 1X No 3 ∏ F	robably 4 □Unknown
S	tw requires been sistemand is should it	Completed				24a. Was a	n 24b. Were a	utopsy findings available
	The law te has age 2	omp				autops perform	ned? prior to death? 2 ☑ No 1 ☐ Ye	
Vita	hysician: The Is his certificate has I director, page 2	Be C	25. Was case referred to medical examiner?		26. Place of Death		41	
<u>-</u>	hysic his ce I direc	ToE	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other	4 Li Nursing Ho	me 5 Reside	ence 6 Other (Sp	ecify)
o u	ing P		1 121 value of 1 chang	njury Work		28d. Describe ho	ow injury occurred	
Division or	r Attending Phy ier death. Irector: After this I by the funeral o	icati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, far		Yes 2 □ No	28f Location (Si	reet and Number or F	Rural Boute Number.
2	l or Attendatter death Director:	Certification:	4 Homicide determined building, etc. (Specify)	, , , , , , , , , , , , , , , , , , ,		City or Town		
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	edical C	29a. Certifier (Check only check only a Decision of the basis of examination and the basis of examinat					
	To the within 2 To the complet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License	e number	2	9d. Date signed (Mor	oth, Day, Year)
	F 3 F 8		1 1 1 1 100	01012	20100 /774		01/09/08	
,			30. Name and address of prison who completed cause of death (Item 23a) (1		38189 (VA NATION		L MEDICAL	
	10		CAROLINE LACEY, CAPT MC USAF				0889-5600	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	South)				
	Registi	ar	JAN 6 6 COOO EN CARGO SEE	The same of the sa				

Physician / Decedent Summer (First, Middle, Last) Joseph A. Andresini 4. Facilities of Decedent Summer (First, Middle, Last) Joseph A. Andresini 4. Facilities of Decedent Summer (First, Middle, Last) Joseph A. Andresini 4. Facilities of Decedent Summer (First, Middle, Last) Joseph A. Andresini 5. Social South Number Plurers Steph A. Andresini 5. Social South Number 2. Decedent Summer (First, Middle, Last) Joseph A. Andresini 5. Social South Number 2. Decedent Summer (First, Middle, Last) Joseph A. Andresini 1. Towns on Baltimore Perry Hall 10. Sites Min. Social South Number of Decedent Interest on Towns on Number of Decedent Interest on Interest on Interest on Number of Summer of Summe			Plea for State	ase Type or Pr State of I	Maryland / D	epartment of	Health and	-	-	
Discipling April Discipling Disc			Registrar			Certificate of	f Death	R	leg. No. 2	8 01169
Stell_Martis St			Joseph A. An	dresini				Month	Day Year	
Social Second Number Size	Examir	er	4a. Facility Name (If not institution	on, give street and number	er)	4b. City, Town,	or Location of Deat	h	4c. County of De	ath
Part		100		10.50	A (1 11-1-1-1			Ta = 1		
Second content 10 1923 Maryland 1920 19						Months Day		(Month, Day	r, Year) (irthplace (State or Foreign Country)
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	No consiste agreement				85			01 (01 1923 M	aryland
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	yland Jow		10a. State 10b. County	у	10c. City, Town	or Location				10d. Inside City Limits
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	a-fsl	cto	MD Bal	timore	Perr	v Hall				1 ☐ Yes 2 No
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	th the or 28	ire					ı	1	10g. Citizen of What 0	Country?
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	23a ust b	la L	16 "G" Brook:	farm Ct.		2112	28		USA	
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	tems	nue	11. Marital Status	Armed Force	s?	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An	
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	s afte			rried 1 ☐ Yes 2[If Yes, Give	No			,		into, oto.
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	hour tural	었				Daniel de la control de la con		V	WH	
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	in 72	Set	(Specify only high	est grade completed)		(Give kind of work don-	e durina most of wo	rking	16b. Kind of Busines	s/Industry
Pasquale_Andersini Alphonsina Mancini 19a. Informate Name Relationship (Type Print) 19b. Mailing Address (Sized and Number of Pland Raule Number. Or Jour Town, State, Zip Code) 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 645 Coventry Rd. Baltimore MD 21286 20a. Name and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations of Sized and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations in the past of Spease and Address of Facility Schilmunck Funeral Home Inc. 9705 Belair Rd. Nottingham MD 21236 20a. Plant Enter the Spease, or completations the death. Do not enter the mode of dying, such as corded or respiratory arrest. Inherital Selection Control and David Month. Plant In the past 12 morthly in the past 12 morth	with iene. thar	E O		College (1-4d	· .		,		D 1 5 .	_
Approximation Americal Consultation (Special Part 1998) Mailing Address (Size and Ambretor of Paral Route Number City or Town, State, 2p Code) Michale Andresini 200. Place of Disposition (Arms) Michale Andresini 201. Special Consultation (Special) Michale Andresini 202. Place of Disposition (Arms) Michale Andresini 202. Place of Disposition (Arms) Michale Andresini 203. Place of Disposition (Arms) Michale Andresini 203. Place of Disposition (Arms) Michale Andresini 204. Place of Disposition (Arms) Michale Andresini 205. Place of Observation (Arms) Michale Andresini 205. Place of Disposition (Arms) Michale Andresini 206. Place of Disposition (Arms) Michale Andresini 207. Place of Disposition (Arms) Michale Andresini 208. Place of Disposition (Arms) Michale Andresini 209. Place of Disposition (Arms) Michale Andresini 208. Place of Disposition (Arms) Michale Andresini 209. Place of Disposition (Arms) Michale Andresini 209. Place of Disposition (Arms) Michale Andresini 200. Place of Disposition (Arms) Michale Andresini 200. Place of Disposition (Arms) Michale Andresini 200. Disposition (Arms) Michale Andresini 200. Place of Disposition (Arms) Michale Andresini Approximate Place of Disposition (Arms) Michale Andresini Michale Andresini Approximate Place of Disposition (Arms) Michale Andresini Mich	filed Hyg other ent, t	Ö		, Last)		keal Estate		ne (First, Middle,		ate
Physician Medical Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Ph	lid be lental ked ic ev		Pagguala Anda	rcini					<i>'</i>	
Physician Medical Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Ph	shou and M mar	-			19b.	Mailing Address (Stree				, Zip Code)
Physician Medical Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Ph	alth a		Michale Andre	sini	İ	645 Covent	try Rd. 1	Raltimore	MD 21286	
Physician Medical Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Ph	of He control		·		comotor	Disposition (Name of	1			or Town, State
Physician Medical Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Ph	Page nent c				te			21/08	Tougon N	m
Physician Medical Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Examiner Physician Physician Examiner Physician Physician Examiner Physician Physician Examiner Ph	rmit. pertin		21. Signature of Funeral Service	e Licensee	bulan	22. Name and Add	ress of Facility Sc	himunak	Funeral Ho	ome Inc
Physician (Modical Physician Modical Examiner Physician (Modical Examiner Physician (Modical Examiner Physician (Modical Examiner) Physician (Modical Ex			Dufan	ie Kine	Ker	9705 Bela	ir Rd. No	ttingham	MD 21236	ine file.
Physician (Medical Examiner) Examiner Examiner Page			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that causes only one cause on each	sed the death. Do n	ot enter the mode of dy	ying, such as cardia	c or respiratory arr	est,	
Due to (or as a consequence of):	Physician		Immediate Cause (Final disease or condition	•		V DICEACE				Onset and Death
Description of the part of the			resulting in death)							
The filt of as a consequence of): Consequence of	Examiner	_	Sequentially list conditions.							
Security	ed sit	ine	OF MANA SURPLINA TO APPROACH MANA	Due to (or)	as a consequence o	ry:				
Security	and I-tran	хаг	that initiated events resulting in death) Last	C. Due to (or	as a concocuonos o	<i>6</i> .				
Septiment of the past of the	S Ci. B			Due 10 (01 1	as a consequence o					
Second S	icate phys s the	dic		d			· · · · · · · · · · · · · · · · · · ·			
Second S	certii nding Ise a	NE S		23c. If yes, outcor	ne pf pregnancy				22d Date of d	-ti
28. Was case referred to medical examiner? The state of the cause of death? 1 Yes 2 No 3 Probably 4 Munknown	leath atter	ciar	in the past 12 months?	1 ☐ Live birth	2 Fetal death					,
28. Was case referred to medical examiner? The state of the cause of death? 1 Yes 2 No 3 Probably 4 Munknown	the cachec	Jysi								
25. Was case referred to medical examiner? 1	s that		Part II. Other significant condit	ions contributing to death	but not resulting in	the underlying cause g	jiven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
25. Was case referred to medical examiner? 1	quire an sig uld b	g p						1 🗆 Y	es 2 No 3	Probably 4 Munknown
25. Was case referred to medical examiner? 1	aw re s bee	Set						24a. Was a	ın 24b Were	autonsy findings available
25. Was case referred to medical examiner? 1	The late has age 2	E O						autops perfor	med? death'	?
State Part	an: tiffica tor, p	0		al	-		26 Place of Dec			es 2∐No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ysici is cer direc	0		Hospital: 1 ☐ Inpa	atient 2 TER/Out	patient 3 DOA	thor			nocify) HOCDICE
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ig Ph ter th		1		njury 28b. Ti					HOSFICE
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature	arth. pr: Af	atio	2 ☐ Accident investi	igation	Jay rear)					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature	r Atte er de recte by th	ti lii		not be mined 28e. Place of i	injury - At home, fari	m, street, factory, office	9	28f. Location (S:	treet and Number or i	Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ital o	Ser		Januari 9,	otor (opocny)			Oily of Yow	n, State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ne Hospi ne Funer pletely fill	dical	Check only 2 Medical	I Examiner: On the basis	s of examination and	death occurred at the for investigation, in my	time, date and place opinion, death occu	e, and due to the curred at the time, o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature	To the within To the comp	ž	29b. Signature and title of certifie	er)		29c. Licer	nse number	2	29d. Date signed (Mo.	nth, Day, Year)
DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093				/ m -			4372	5	1/17/	08
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1/X0/		30. Name and address of person	who completed cause o	f death (Item 23a) (7	Type, Print)				******************
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	10.		DR. TARIQ MAHN	100D 2300 DU		LEY RD. T	'IMONIUM,	MD 21093	}	
		te ar	31. Date filed (Month, Day, Year,	32 Regis	strar's Signature	aparlis .				

DHMH 17 Rev 1/2001

Piease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 3:35 AM 17,2008 NORMAN BROWN, SR. January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNION MEMORIAL HOSPITAL BALTIMORE Birthplace (State or Foreign Country) Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 ★ M 2 □ F MD 67 APR. 18, 1940 Director 220-36-5044 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be account. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21231 19 N. COLLINGTON AVE. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE COORDINATOR HOSPITAL 11TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ ARMSTRONG BROWN ERMA BROWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19 N. COLLINGION AVE., BALTIMORE, MD JOYCE BROWN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 5712 O'DONNELL ST. 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 01/22/2008 | BALTIMORE, MD 21224 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 2007-09 EASTERN AVE., BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part1 Enter the disease shock, or heart failure. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) SeptiE Shock days **Physician** /Medical Due to (or as a consequence of): Examiner 5 days Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) months Non-Small Cell Lung Cancer physician and the burial-transit Stage IV Due to (or as a consequence of): Physician/Medical as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed certificate ! 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 📉 No 1 Inpatient this After this funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

P.O. Box 68760, Records, Division or Vital

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours at er death.

To the Funeral Director A the filled in by

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

D. VM, D.O.

29c. License number AT 2438946

Hospital,

29d. Date signed (Month, Day, Year) January 17,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. O. D. Union Vu

Memorial 32. Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

4

Medical

3

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humanistrance. Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

မ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

ner

dical Exami	Cause (Disease or injury that initiated events resulting in death) Last	c. Tarkinsons Due to (or as a consequence of): Dementia	Seaso		
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown		topic pregnancy ther (specify)		23d. Date of delivery Month Day Year
立	Part II. Other significant conditions	contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ed by	History of 1	una Cancer res	eckd	1× Yes	2 No 3 Probably 4 Unknown
Complet	Chronic Obstrac	tive Pulmonary D	isease	24a. Was an autopsy performed? 1∐ Yes 2 ∑	
Be (25. Was case referred to medical examiner?			ath (Check only one)	
0	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing F	lome 5 ☐ Residence	6 Other (Specify) Home
ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred
Certification:	3 Suicide 6 Could not be determined		, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Medical C		hysician: To the best of my knowledge, death or miner: On the basis of examination and/or inves and manner stated.			
Me	29b. Signature and title of certifier	1-	29c. License number	29d. [Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

8218 Wisansin Avet

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print)

2008 3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 18, 2008 Bernice M. Brigerman January 11:45am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie Health and Rehab Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Hours 1□M 2√X 81 214-24-1726 March 22, 1926 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 □Yes 2 ☑ No Director Maryland | Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.

Department of the Men 2 is marked other than "natural", or items 23a or morocant; if them 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a my injury or other traumatic event, the Medical Examiner must be a 225 Arundel Road 21122 United States Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No ģ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Teletype Operator B&O Railroad n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lloyd C. Copper Margaret Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Arundel Road Pasadena, MD 21122 Lloyd C. Copper (brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐Removal from State Bayview Crematory 1-21-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign a Se of uner 22. Name and Address of Facility Service License McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, MD 21122 Wayne Osterling disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ballure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chromic Kirney /Medical Due to (or as a consequence of) Examiner sertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-transit Mellitus **Y**E Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation al or Attendi after death. I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a 29a, Certifier 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

State

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760.

DHMH 17 Rev 1/2001

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

2 3 2008

Agajeln

and manner stated

MASSAMY

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D56950

ress of person who completed cause of death (Item 23a) (Type, Print) Ch Agaill My 1411 Maliron Park Drive Sonto 16 Glen Burnie My Zorbi

29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Completed Be Certification:

Medical

autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 2 ER/Outpatient 3 DOA 1 ☐ Yes 4 ■ Nursing Home 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ ★6

01-18-08

0 9

State

Registrar

Hirvara. 31. Date filed (Month, Day, Year) JAN 2 3 2008

Bright fred 32. Registrar's Signature

515

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

95274

m should

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIFM#8, perFH C*/5.1/29/08 WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** -Month 3.20 AM January Agness Fulton Bond 2008 S/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 830 W. 40th Street, Apt. 764 N/ABaltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birt Mayar 11, 1924 irthplace (State or Foreign (Month, Day) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F 214-20-3061 83 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at Director 1 X Yes 2 □ No MD N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Funeral items 23a 830 W. 40th Street, Apt. 764 21211 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🗷 No Specify: 2 Specify: 3 Widowed 4 Divorced White natural al Hygiene. I other than "natura event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Private School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental H John S. Fulton Agness Cator ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau once. John M. Bond - Husband 830 W. 40th Street, Apt. 764, Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/21/2008 Baltimore, MD 21. Signature of Funeral Service Licensee Williams ²² Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 48 Keurs Immediate Cause (Final disease or condition resulting in death) adrenal ensufficiency **Physician** /Medical Due to (or as a consequence of): **Examiner** terminal ellege Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine adriplegia due to transverse myelikus and The law requires that the death certificate be executed and Due to (or as a consequence of physician a the burial-1 Cerencal cord stensors Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performe 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ျ 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director; d in by the 6 Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical and manner stated. within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Thegue 10 D13657 January 19, 200 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THE PREGOR, 830 W. 40th STREET, BALTIMORE, ODD 21211 O ISABELLE 32. Registrar's Signature 31. Date filed (Month) State Registrar

Fax to ME

#23a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death **Physician** January 18 2008 2120 Рм Goldie Opa1 Bailey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health of Denton Caroline Denton Social Security Number 218-42-3432 If Under 1 Year | If Under 24 Hrs. 6 Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2X F Yrs Director 87 25,1920 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits show r 28a-f sh Ridgely 1 □ Yes 2 TNo Director Maryland Caroline 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 21660 24480 Reed Court death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 ∐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supermarket Cashier Unkn 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula Jordon Robert F. Roark ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s
Department of Health ar
Important: If Item 27 Is
eny Injury or other trau 24480 Reed Court Ridgely, Maryland Mrs. Ruby Chisholm (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 1/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dementia Racc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery TO 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t Certification: 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Hospital or All 24 hours after d 4 Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00047534

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Wafik Zaki, 920 Market Street, Denton, MD 21629

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 22, 2008 6:25 A M January Burdyck Dorothy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Nursing Home Baltimore Co. Dundalk Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 T F 3,1928 Maryland Director 79 219-22-7056 Dec. Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show must be notified at 1 ☐ Yes 2XXNo Director Edgemere Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or 21219 United States 4628 Greencove Circle Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Completed by 3 Widowed 4 Divorced White natural 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Megines. Flementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. Clerk 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Wachowiak ပ Walenty Soltysiak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgemere, Maryland 21219 Donna M. Hutchinson (Daughter) 4628 Greencove Circle 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Høly Rosary Cemetery 1/25/2008 4 □ Donation Other (Specify) Baltimore, Maryland 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
7922 Wise Ave. Dundalk, Maryland 21222 21. Signature funeral S 23a. Part1. Enter the disease, or complications that caused in shock, or heart failure. List only one cause on each line caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final EROSCIEROTIC CARDIOVASCULAR DISPACE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 222No page 1⊟ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 🛭 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) ဥ 1 Tes 2**X** No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manne eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 1 atural 2 Accident Injury М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: Director:

n 24 hours the Funeral Dir To the

State Registrar

29a. Certifier

29b. Signature and title of certifie

Medical

Savinder K. Julka,

29c. License number D 27188

\(\frac{\text{Y}_\text{\tin}\text{\te}\text{\texit{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\

29d. Date signed (Month, Day, Year)

January 22, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 2 Market Place Dundalk, Maryland

31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

10

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physiclan: within 24 hours a

To the Funeral I

DHMH 17 Rev 1/2001

1

State Registrar (Check only one)

31. Date filed (Month

29b. Signature and title of certifie

mv (.

and manner stated

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30

00059943

29d. Date signed (Month, Day, Year)

21,2008

			For State	State of Mar		oartment ertificate				giene Reg. No.20	0.8	ΛI	179
		-	Registrar 1. Decedent's Name (First, Middle, Li	ast)	- 00	Timeate	UI Deali		. Date of Dea	ath	UU	3. Time o	f Death
	Physic		Jeannine Mari	,					Jan.	_) Š ^{ear}	12:0	
	/Med Exami		4a. Facility Name (If not institution, gi			4b. City, To	own, or Location	n of Death		4c. County			
4			Gilchrist Hos	spice Cent	er	Tow					imo	ce	
	Funera Director	4.0	218.54.3568	Sex 7. Age (1 M 2 1 5 8	In yrs. last birthda Yrs.		Year If Under Days Hours	Min.	Date of Birt (Month, Day		9. Birthp Cour N		or Foreign
	and		Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or	Location						Od. Inside C	City Limits
	Maryl f sho	ro	MD N/A		Baltimo	ore						1 XYes	2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip C	ode			10g. Citizen of	What Cour	ntry?	
	th wit 23a o ist be		1415 Park Ave	nue #1		21	217			U.S.A	•		
	r dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	3. Was Deceder	nt of Hispanic C y Cuban, Mexic	Drigin? (Speci an, Puerto Ri	fy Yes or No- can, etc.)	14. Rad Bla	ce - Americ		
36	s afte	by Fu	1 ☑Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2	¥No Specif	fy:		Specif	y: W]	hite	
Ş	2 hour	ed t	15. Decedent's E	Education	16a. Dec	cedent's Usual	Occupation			16b. Kind of B			
7.	e. Ban "n. Media	plet	(Specify only highest gas Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)		ve kind of work . DO NOT use				John I			choo
2	ed wit ygien ygien ier th	Completed		2	Fina	ancial				Of Nu		g	
ב	yion is the field within 72 hours after death with the Maryland Mental Hyglene. Mental Hyglene. arked other than "natural", or items 23a or 28a-f show atte event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Las Frederick Joh					her's Name (i :ie Ju		Maiden Surnar Byrn	,		
2	hould d Mer marke	은			1. 10h Ma	ilina Address (,		Codo)	
2	nd 2 s lith an 27 Is		19a. Informant's Name/Relationship Judith Eileen	Paris/par	tner 1	115 Pa	rk Ave	#1.	Balti	more.	MD	21217	,
g	s 1 ar of Hea		20a. Method of Disposition		20b. Place of Dis			Dat		20c. Location			
Ē	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		Chesape		rem.	01.21	08	Beltsv:	ille	, MD	
Baltimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice	217 Mo						hen D Bal		hrman MD	nPA
	-64		23a. Part1. Enter the disease, or cor shock, or heart failure. List onl	nplications that caused th		enter the mode	of dying, such a	as cardiac or	respiratory ar		Í	Approxima Interval Be	ite etween
	Physician		Immediate Cause (Final disease or condition	ž.	blaston	ng N	rultif	of me	,			Onset and	Death
9	/Medical Examiner	THE STATE OF	resulting in death)	Due to (or as a c	•							-1	7
- 1	Lammer	'n	Sequentially list conditions,	b Due to (or as a c	consequence of).								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duc to (or as a c	onsequence oi).								
_	cate be executed physician and the burial-transit		that initiated events resulting in death) Last	C. Due to (or as a c	consequence of):								
8760	ite be iysicia ne bur	dical		▲d									
Œ	ng ph	Med	IF FEMALE:										
á	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf 1 ☐ Live birth 2	Fetal death	B □Ectopic pre					ate of delive	ery Dav	Year
C	he de the a	ysic	1 ☐ Yes 2 【 No 9 ☐ Unknown	4□Pregnant at tir 9□Unknown	ne of death	5 ☐ Other <i>(sp</i> ed	cify)					/	
۵	that the ded by		Part II. Other significant conditions	contributing to death but I	not resulting in the	underlying cau	ıse given in Par	t i.	23e. Did to	obacco use con	tribute to t	he cause of	death?
rd o	quires n sign ald be	d by							1 🗆 🗅	res 2 No	3 ☐ Prot	oably 4	Unknown
0	aw rec	olete							24a. Was		Were auto	psy findings	available
ă	The lav ate has	Completed					-		autor perfo 1□ Yes	rmed? 2 D No	prior to co death? 1 Yes	mpletion of 2□ No	cause or
±	cian: ertifica	Be C	25. Was case referred to medical examiner?					ce of Death (9~
7	Physician: The la r this certificate has ral director, page 2	T _o	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient				Nursing Home			ner (Specil	NOS	pue
2	ding f	ion:	27. Manner of Death 1 Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Y	'ear) 28b. Time Injun	/ M 280	c. Injury at Work? 1 ☐ Yes 2 [d. Describe i	now injury occu	red		•
Division or Vital Records P.O. Box	or Attending latter death. Director: After in by the funer	Certification:	3 Suicide 6 Could not l	ne 280 Place of injune	- At home, farm,				f. Location (5	Street and Num	ber or Rura	al Route Nui	mber,
200	al or al or al Direction	erti	4 ☐ Homicide determined	building, etc. ((Specify)				City or Tov	vn, State)			
1	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	edical (thysician: To the best of aminer: On the basis of example and manner state	xamination and/or								(S)
J	To the within To the comple	Me	29b. Signature and title of certifier			29c.	License numbe	r		29d. Date signe	ed (Month,	Day, Year)	> 7
			> alran	no		1	5830	5		Janda	ry	18 20	08
			30. Name and address of person who	completed cause of dear	th (Item 23a) (Typ 679(V.)		1769	TUN SON	SMO	29d. Date signe Sam Da 21264			
		ate	31. Date filed (Month, Day, Year)	32. Registrar's		broadly is	<u> </u>						
	Regis	1151	LAN 2 3 2	1 11 10 A 36 P 12 18 18 18 18 18 18 18 18 18 18 18 18 18	15 M. S. C.	A Parket Galler							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 18^{Day} 2008 **Physician** 8:30 Doris Ε. Brown /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1617 N. Caroline Street Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number , Year) **Funeral** Hours Days 1 □ M 2 □ F 11-10-1943 216-40**-**8739 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 1617 N. Caroline Street Funeral 21213

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black Specify: þ 3 ☐ Widowed ★ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Day Care Kitchen Aide N/A 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Christine Evans Virgil Martin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 Is any Injury or other trau Yolanda J. Brown - Daughter 1412 N. Bond Street Balto, MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt Zion Cemetery 1-23-2008 Lansdown, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that our sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metaster. Ca Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician and strans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical e attending ph d for use as th IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐Live birth Month Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Z Yes 2 □ No 3 □ Probably 4 □ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn 2 No 1⊟ Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 20 No 5 Residence 6 □Other (Specify) 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dit 28a. Date of Injury (Month, Day Year) 27. Manner of eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Z'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 1 D0066724 MID

State Registrar 30. Name and address

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

HOL

Baltimore MD 21231

person who completed cause of death (Item 23a) (Type, Print)

LIVER

32. Registrar's Signature

Phy Ex

	1 - State Registrar Amend 7&10d, perF,	₃ 875, 1/31/08 TT <i>Ce</i>	rtificate of Death	Reg. N	2008	3. Trime of Dealth			
1 	Ulysses	Α.	Banks	Month D	18 2008	11:14			
Y .	4a. Facility Name (If not institution, give street a 3302 Aurora Lane		4b. City, Town, or Location of Death Baltimore	4	c. County of Deatl	h			
	5. Social Security Number 6. Sex 491–26–3434 17 M 24	7. Age (In yrs. last birthday, 78 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 10 02	9. Birth Co. 29 MC	nplace (State or Foreig untry) •			
5	Usual Residence of Decedent 10a. State 10b. County MD NA	10c. City, Town or L Balti				10d. Inside City Limit			
וו חוובכנסו	10e. Street and Number 3302 Aurora Lane	В	10f. Zip Code 21207		Citizen of What Co	untry?			
Dy Fulleral	1 □ Never Married 2 ☑ Married 1 ☑ If Y	s Decedent Ever in U.S. led Forces? Yes 2 \(\subseteq \text{No} \) ss, Give r or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, W						
Completed	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Col	ege (1-4or 5+) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king	Kind of Business/	•			
ב ב		Years C		ficer S ne (First, Middle, Maide a Applewh	en Surname)	f Marylar			
2	19a. Informant's Name/Relationship (Type. Prin	e 19b. Maill	ing Address (Street and Number of Ru 06 Bogley Rd #2			Zip Code) 21244			
	Phyllis Banks-Wile 20a. Method of Disposition 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Cemetery, crematory or other place) 1/30/08 0 0 0 0 0 0 0 0 0								
cai Evallillei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Top Alserse			Interval Between Onset and Death			
	in the past 12 months?		□Ectopic pregnancy □ Other (specify)	3	23d. Date of del Month	ivery Day Year			
2	Part II. Other significant conditions contributing The DIMBETES	g to death but not resulting in the $\mathcal{M}\mathcal{E}(II\mathcal{TMS}')$	underlying cause given in Part I.	23e. Did tobacc	23e. Did tobacco use contribute to				
29	24a. Was an autopsy performed? 1 Yes 2 No 1								
completed by ring	25 Was against a madical		20 51	1 Yes 2 1					
o se completed by Life	1 Natural 5 ☐ Pending 2 Naccident investigation 3 ☐ Suicide 6 ☐ Could not be 280	Date of Injury (Month, Day Year) NA 28b. Time Injury	ont 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	th Check onl one ome 5 Residence 28d. Describe how in					
for far paradurable and a	examiner? 1 Yes 2 No Hospital 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e.	Date of Injury (Month, Day Year) Place of injury - At home, farm, st building, etc. (Specify) To the best of my knowledge, dea	ont 3 DOA Other: 4 Nursing H of 28c. Injury at Work? M 1 Yes 2 No	th Check onl one ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, Str.	and Number or Ruate)	ural Route Number,			

6+1

State Registrar

31. Date filed (Month, Day, Year)

JAN 23

Const

32 Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 9 17 17 19 17 / Elepartment of Health and Mental Hygiene Certificate of Death Reg. No... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Geneva Buggs 1: 45 a M /Medical 01/19/2008 4a. Facility Name (If not institution, give street and number)

Marion Health of Overlea Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 180-24-6182 1 □ M 2 🕅 E 88 Director April 22, 1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or items 23a or 28a-1 show eny Injury or other treumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6116 Belair Road 21206 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African American 1 ☐ Yes 🔀 No Snecify. ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) unk College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be Otis Buggs ပ 19a. Informant's Name/Relationship (Type. Print) Shawn Harby / Guardian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 South Conkling Street; Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion Cemetery 01/25/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 North Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Further to sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should be in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner rasu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed attending physician end for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown signed by the tylbuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed s certificate has b irector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 28 No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ဥ 1 🗀 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type Brint) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 23

DHMH 17 Rev 1/2001

Registrar

			For State	State of Maryland			allu ivie	marriyy	iene	
			Registrar		Certificat	te of Death			g. No. 2	18.01.1
	Physicia	an	Decedent's Name (First, Middle, La	_	0 - 25		2	. Date of Deat Month	Day Y	ear 3. Timel of Deal
	/Medic		KEGINALD	P CAMP.		T		JAN	20 20 4c. County of	705
	Examin	er	4a. Facility Name (If not institution, give			Town, or Location of				
		70	STELLA 1 5. Social Security Number 6. 8	MORRIS ex 7. Age (In yrs. Is	ast birthday) If Unde	CKEYSU r 1 Year If Under	24 Hrs. 8	Date of Birth		O. Birthplace (State or For
	Funeral Director			19 2□F 39	Yrs. Months	Days Hours	Min.	(Month, Day,	Year)	BALTE MD
			Usual Residence of Decedent					20-9 12	7 102 1	0.1076 1.70
	how at		10a. State 10b. County	1.1	, Town or Location					10d. Inside City Lin
	a-f s	ctol	mo Baltim	are Wil	ndsor MI	11				1 □ Yes 2.2
	or 28	ire	10e. Street and Number		10f. Zip			1	0g. Citizen of Wh	at Country?
	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural" or items 23a or 28a-f show do other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	3301 WILD C	henry RD		31244			03	
	tems er m	nue	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Dece If Yes, spe	dent of Hispanic Ori ecify Cuban, Mexicar	gin? (Specif n, Pu <i>e</i> rto Ric	y Yes or No- can, etc.)		American Indian, White, etc.
36	s afte	by F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 ☐ Yes	2☑No Specify:			Specify:	BLACK
8	ural'	q p	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	16a. Decedent's Usu	ual Occupation			16b. Kind of Busi	
215-0036	n 72 "nat edlo	lete	15. Decedent's E (Specify only highest gr.	ade completed)	(Give kind of wo	ork done during mos use retired)	t of working	- 1	TOD. KING OF BUSI	ness/muustry
12	with iene. thar he M	E I	Elementary/Secondary (0-12)	College (1-4or 5+) V/A	2	MOTA		I .	Show	METHL CO
d 2	Hyg Hyg ent, 1	Be Completed	17. Father's Name (First, Middle, Last						Maiden Surname)	
an	wild be Mental arked c	To B	HAROLD SE	77		CA	DA La	in C	AMPL	3211
Maryland 21	2 should and Men is marke aumatic		19a. Informant's Name/Relationship	Type. Print)	19b. Mailing Address					
	† and 2 Health a em 27 is sther trau	j	CAROLYN 1	09.9N	33010	VILD Che	nn4	eD.		21244
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition		ace of Disposition (Na	me of I	Dat	e		ity or Town, State
Baltimore,	Pages nent of I int: If Its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation / 5 ☐ Other (Speci	IBemoval from State 1	VEODLAW	1	JANO	26 2000	WOOD	SWW MD
alti	permit. Pag Department Important: I any Injury o	1	21. Signature Muneral Service Lice	-/-	22. Name a	nd Address of Facilit	ty	Ciony	9	BALTO, IND
m	8 8 1 6 8		Sans (1)	mel	270	PRED	141	LTON	PASS	BALTO, In D
	-84		23a. Parti. Enter the disease, or con shock, or heart failure. List only	one cause on each line	. Do not enter the mo	de of dying, such as				Approximate Interval Between
6	Physician		Immediate Cause (Final disease of condition	Bra.	in /41	mor				Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	ence of):					
	Examiner		Sequentially list conditions.	b						
-	₩ ±	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or miny)	Due to (or as a consequ	ence of):					
	ficate be executed physician and stransit the burial-transit	xan	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consequ	ence of):					
8760,	be e sician buria	a			,					
	ficate phys s the	edical		d						
Вох	attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnar					23d. Date	of delivery
m	death a atte	icial	in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de					Mont	
O.	that the de led by the a detached f	hys	9 Unknown	9□ Unknown						
Records, P	The law requires that the death certif te has been signed by the attending age 2 should be detached for use as	by P	Part II. Other significant conditions	contributing to death but not resu	Iting in the underlying	cause given in Part I		23e. Did tot	acco use contrib	ute to the cause of death
ğ	aquire en sig vuld b	ed b	55/3012 -	die also				1 □ Ye	es 2 No 3	□ Probably 4 X Unkn
ည္က	law re	Completed						24a. Was a	n 24b. W	ere autopsy findings avail or to completion of cause
		E O						perform	n <u>e</u> d? de	ath? □Yes 2 □ No
ita	striffica ctor,	Be C	25. Was case referred to medical examiner?			26. Place	of Death (Check only on		
or Vital	hysic his ce I dire	인	1 ☐ Yes 2 X No		ER/Outpatient 3 D		ursing Home	5 Reside	ence 6 X Other	(Specify) HOSPIC
u	ding Physician: The lav n. After this certificate has funeral director, page 2 !		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?		d. Describe ho	ow injury occurred	d
Division		Certification:	2 Accident investigation 3 Suicide 6 Could not be		M	1 Yes 2				
<u>≅</u>	or At fter d Direct in by	ıţ	4 ☐ Homicide determined		me, tarm, street, tactor	гу, опісе	28	City or Town		or Rural Route Number,
ر ت	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 ▼ Certif√ing P	evelcian. To the hest of my know	vladne death occurred	t at the time date or	nd place on	d due to the o	ausa(s) and man	ner as stated
	Hos 24 hc Fun etely	Medical	(Check only one)	nysician: To the best of my know miner: On the basis of examinat and manner stated.	ion and/or investigation	n, in my opinion, dea	ath occurred	at the time, d	late and place, ar	nd due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	, ,	29	c. License number				(Month, Day, Year)
	⊢ ≯ ⊨ ŏ		1 Velah	ed - 20		1/169	,04		1.21	
		1 2								
•	2	1	30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)					
•	3		30. Name and address of person who DR. EDDIE NAKHU			RD TTMON	TIIM	MD 210	03	

		Pleas	e Type or Pri	nt in E	Black In	delible Ink.	Ensure A	l Copies	Are Legible	э.
		For	State of M	arylan			lealth and M	lental Hy	giene	
		1 - State Registrar			Ce	rtificate of	Death		Reg. No.	181108
Physic	ian	1. Decedent's Name (First, Middle,	· -					2. Date of Dea Month	Day Ye	3. Time of Death
/Medi		Mary Jus- 4a. Facility Name (If not institution,	tina Cox	•		4h City Town o	r Location of Death	Januar	y and ac	
Exami	ner	Washington Coun					gerstown)		hington
Funeral			6. Sex 7. Ag	je (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Birt (Month, Day	th 9	Birthplace (State or Foreign Country)
Director		229-22-0184	1□M 2 X F	81	Yrs.	World Days	Tiodis Iviii.	July 29		l'irginia
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
Mary B-f sh	io	Maryland Washin	gton		+	lagerston	in			1 ☐ Yes 2 No
or 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show alical Examiner must be notified at	ra	14014 Marsh 2			o I.a	217			03	
ter de Item	Funeral	11. Marital Status 1 X Never Married 2 Marrie	12. Was Decedent Armed Forces? d 1 ☐ Yes 2				lispanic Origin? (Span, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black, V	American Indian, White, etc.
urs af	ò	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 No	Specify:		Specify: V	Vhite
"natur	Completed	15. Decedent' (Specify only highest	s Education grade completed)		16a. Dece	dent's Usual Occup	oation during most of work d)	ina I	16b. Kind of Busin	ess/Industry
	ğ	Elementary/Secondary (0-12)	College (1-4or		1	DO NOT use retire			Reli	glon
be filed within 72 horal Hygiene. d other than "natu		17. Father's Name (First, Middle, L	ast) 5 · t		10,00	31003 0		e (First, Middle,	Maiden Surname)	3.0.,
lid be lental ked o	To Be	Charles Jos	eph Cox.	50			Allen	e Luc	ille Bin	naleu
and Men s marke		19a. Informant's Name/Relationsh			19h Maili	ng Address (Street	and Number or Rur	al Route Numbe	er City or Town Sta	eta Zin Coda)
1 and 2 Health a em 27 is	8	Kathy Raoa	/ Friend -1	POA	957	Glen Mac	y Drive	Fugue	xy-Vari	na, NC 27526
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Mone.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		۰	riace of Dispo cemeterv. cre	osition (ivame of matory or other pla	ce)	Jate	20c. Location - City	y or Town, State
iit. Pa artmer ortant Injury		4 Donation 5 ☐ Other (Sp 21. Signature of Juneral Service L		Ana	terry G	+ ff Kegist	ry January	24,2008	Hangvery	<u>no</u>
permit. Departr Importa any Inju		A			74	522 Canne	Her Dave	Suite P.	Hanover, Honover,	mn 21076
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that cause	d the deat	h. Do not en	ter the mode of dying	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between
Physician	١.,	Immediate Cause (Final disease or condition	iny one cause on each	- 1	t, c	canc		lun		Onset and Death
/Medical		resulting in death)	Due to (or as			0		Λ,		
Examiner	-	Sequentially list conditions,	b. Care Due to (or as			0 + U1	mary	Blac	10121	
nsit de 🗡	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Chri	~ .	ob	truct:	ve Lu	ng D	i seasa	
execu an and rial-tra	Exa	resulting in death) Last	Due to (or as	a conseq	uence of):					
ate be nysicia he bui	ical		d. Can	dia	myor	alhy				
ertifica ling ph	Physician/Medica	IF FEMALE:	00- 11		-					
eath c attenc for us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant a	2 Feta	I death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date o Month	
the d	Jysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	it time or o						
s that	by Pi	Part II. Other significant condition	4		ulting in the u	ınderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
equire en sig ould b			itus ms.	9				10	Yes 2□No 3[Probably 4 Onknown
law r nas be	Completed							24a. Was	psy prio	re autopsy findings available or to completion of cause of
The icate I	Sol							perfo 1⊟ Yes	ormed? dea 2 No 1 □	th? Yes 2 □ No
slcian certif	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	0 ==	5D/0-1-1-	Oth	26. Place of Deat			
a Physer this eral di	7: To	27. Manner of Death	28a. Date of Inj	ury	ER/Outpatie	III 3LI DOA	4 LI Nursing Ho		dence 6 Other (Specify)
ath. pr: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	ay Year)	Injury		rk? Yes 2□No			
or Atte ter de irecte	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Hornicide determin		jury - At he tc. <i>(Specil</i>	ome, farm, st	reet, factory, office		28f. Location (S	Street and Number own, State)	or Rural Route Number,
pital o		29a. Certifier 1 Certifying	Physician: To the best	of my koa	wlodgo dool	th annured at the ti				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner s	of examina	ation and/or in	rvestigation, in my	opinion, death occur	red at the time,	date and place, and	er as stated. I due to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signed (A	
		fand	muhun			20	60396		01/22	108
1		30. Name and address of person v	who completed cause of	death (Iten	n 23a) (Type,	Print) 1		0/1	c +	0 21774
St	ate				ature		170.4	exstar	m m	0 21740
Regist		31. Date filed (Month, Day, Year) JAN 2 3 200	8 / 2 2	All s	Joseph					
NII 1 1 2 D	2001		«V		67					

Dec 26, 1931 Maryland 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc White 16b. Kind of Business/Industry Shipping Company 18. Mother's Name (First, Middle, Maiden Surname) Louise Brauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Blue Water Ct., Glen Burnie, Md. 21060 20c. Location - City or Town, State Bayview Crematory, Inc. 1/21/08 Baltimore, Maryland McCully-Polyniak Funeral Home, P.A. <u>3204 Mountain Rd., Pasadena, Md. 21122</u> Approximate Interval Between Onset and Death wuch as cardiac or respiratory arrest, 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 👱 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 21230 901 Egd an 1 mus 31. Date filed (Month, Day, Year)
JAN 2 3 2008 32. Registrar's Signature 2 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4:45 a ^M

9. Birthplace (State or Foreign

17,2008

4c. County of Death

Anne Arundel

Registrar DHMH 17 Rev 1/2001

0

State

	i	For State Registrar	State of Ma	ryland / Dep Ce	ertificate of l			giene Reg. No!) 🕦 (12 11186
Physici	an	1. Decedent's Name (First, Middle, La ELLSWORTH	est)		COBUN)	2. Date of De Month	Day	Year MLY TM
/Medic Examir		4a. Facility Name (If not institution, given	re street and number)			or Location of Death	JANU	4c. County o	
Funeral Director		234-32-9327	Sex 7. Age	MeDical Q (In yrs. last birthday Yrs.) If Under 1 Year Months Days	BALTIM If Under 24 Hrs. Hours Min.	8. Date of Birt	N/I	9. Birthplace (State or Foreign Country) West Virginia
yland now art		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			<u></u>	10d. Inside City Limits
ne Mar Ba-f st otified	Director	7	imore			Dundal	Lk		1 □Yes 2X No
h with th	al Dire	10e. Street and Number 101 German Hil	1 Road		10f. Zip Code	222		10g. Citizen of W	
partilliore, IMarylatina Z 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? MRYYes 2 N If Yes, Give Year or Dates:	ver in U.S. 13 0 1942-46	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Race Black Specify:	- American Indian, , White, etc. White
n 72 ho "natur edical E	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Giv	edent's Usual Occu re kind of work done DO NOT use retire	oation during most of work d)	ing	16b. Kind of Bus	iness/Industry
CIC diene. griene. er than the M	Somp	Elementary/Secondary (0-12) 12 Years	College (1-4or 5-	+)	Crane Ope	_		Steel :	Industry
d be file	Be	17. Father's Name (First, Middle, Las Earl Cobun	")				,	Maiden Surname)
Maryland Z IZ IS nd 2 should be filed within alth and Mental Hyglene. 27 is marked other than "retraumatic event, the Mee	P P	Earl Cobun 19a. Informant's Name/Relationship Mrs. Edna Cobu				and Number or Rur ill Road	al Route Numbe	er, City or Town, S	
Daltimore, bernit. Pages 1 a bepartment of He mportant: if item my injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Speci	(y)	Holly H	ill Mem.	Gdns 1/2		Middle	City or Town, State River, MD
Departition of the control of the co		21. Signature of Funeral Service Dies	Asee		22.Name and Addro Duda-Ruc 7922 Wise	k Funeral Ave. Du	Home of	f Dundal Maryland	k, Inc. 21222
Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition			nter the mode of dyi	ng, such as cardiac	or respiratory a		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	a	consequence of):					
nsit p	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or injury	b. Due to (or as a	consequence of):					
ficate be executed physician and the burial-transit	edical Exar	that initiated events resulting in death) Last	CDue to (or as a	consequence of):			-		
A 00 vertifical ding phy		IF FEMALE:	000 16.000 0.0000000						
the death cer y the attendin	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome particle in the second	2 ☐ Fetal death 3	☐Ectopic pregnand ☐ Other (specify) _	у		23d. Date Mon	of delivery th Day Year
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	ρ	Part II. Other significant conditions	contributing to death bu	t not resulting in the	underlying cause gi	ven in Part I.		obacco use contri Yes 2 No	bute to the cause of death? 3 ☐ Probably 4 X Unknown
The law recate has be page 2 sho	Completed						24a. Was autoj perfo	psy pr prmed? d	/ere autopsy findings available rior to completion of cause of eath? □Yes 2□No
vital siclan: certifical irector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	nt 2 ☐ ER/Outpatio	ont 2000 Oti	26. Place of Deat			
tending Phy leath. tor: After this the funeral d	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Inju	4 LI Nursing Ho		dence 6 □Othe how injury occurre	
al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, s . (Specify)	street, factory, office		28f. Location (: City or Tox	Street and Numbe wn, State)	er or Rural Route Number,
he Hospit in 24 hours he Funers pletely fille	Medical C	29a. Certifier (Check only one) Certifying P	hysician: To the best of miner: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	ime, date and place, opinion, death occur	and due to the rred at the time,	cause(s) and mar date and place, a	nner as stated. ind due to the cause(s)
To t with To t	Σ	29b. Signature and title of codifier	20/	MD	29c. Licens	se number		_	(Month, Day, Year) ARY 17, 2008
6+1		30. Name and address of person who						- 110	2.0.7.1
Sta	ite	31. Date filed (Month, Day, Year)		10 EASTER	4	UE BA	LTIMORI	E, MD	21224
Registi		JAN 2 3 2	008	5 B F	1341				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Nume1a Carpenter 2008 9:30pm M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Lutheran Village Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, June 8 7. Age (In yrs. last birthday) Funeral Ye*ar*) 1914 1□M 217F 216-44-9365 93 WA Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County show 1 ☐ Yes 2 🔀 No Westminster be notified MD Carroll Director 28a-f s 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 USA 21158 300 St. Luke Circle 'natural", or Items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23: any injury or other traumatic event, the Medic I Examiner must once. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify 3 ♥ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) NIH Elementary/Secondary (0-12) College (1-4or 5+) secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Viniola Peter Newman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 Country Fair Ln. Sykesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) Sandra Jones (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 1-22-08 Sykesville, MD All County Cremation 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Haight Sterber P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and D Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (was a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter this religious Cause (Disease or injury that initiated events resulting in death) Last Examine iplial or Attending Physician: The law requires that the death certificate be executed ours after death.

Beral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a cor quence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 2 10 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Sertifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination and manner stated. edge death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only for investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29b. Signature and title of contifier 29d. Date signed (Month, Day, Year) ath (Item 23a) (Type, Print) 30. Name and address of person

State Registrar 31. Date filed (Month, Day,

Year)

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 19 James Henry Charlton () 2008 11:40 a^M January /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Brookegrove Nursing & Rehab Sandy Spring Montgomery 6. Sex 1X M 2□ F If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) APR 8 1918 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 89 Director 136-03-5798 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or Items 23a or event, the Medical Examiner must be r 18131 Slade School Road 20860 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 41-46 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Industrial Engineer Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Int: If item 27 is marked of Charlton Charlton Harry Rose 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Anne Wheeler - Daughter 5007 Linganore Circle, Monrovia, MD 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any injury or of 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Metro Crematory, Inc. 1/21/2008 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams ²² Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final C>00 **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examiner Division or Vital Records, P.O. Box 68760, $ec{oldsymbol{ec{\zeta}}}$ that initiated events resulting in death) Last Due to (or as a consequence of) the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIGNESIS 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 2 Mo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗀 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 2

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

lucker appun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Christopher J. Mays, MD 1814 Prince Philip Dr. Ohmy, MD 20832

29c. License number

D39793

29d. Date signed (Month, Day, Year)

Jamany 21, 2003

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

HOLFE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Timothy Cruttenden Andrew January 11:20 19, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 2833 Rogers Avenue Ellicott City Howard 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F 26 Maryland Director 212-15-9780 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f shov notffied at MD **Funeral Director** Howard Ellicott City 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be a 2833 Rogers Avenue 21043 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4ar 5+) Elementary/Secondary (0-12) Actor Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur T. Cruttenden Catharine Leedv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catharine L. Cruttenden/Mother 167 Trinidad St Naples, FL 34113 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2008 Baltimore, MD 21. Signature of Funeral Service Licensee C. Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD Todd Dring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Marflus immediate Cause (Final MALIGNANT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, from Leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine signed by the attending physician and d be detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical ANDREW IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes No CRITTENDEN To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate i completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original death occurred. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tausanteun Blud/BaltomD 21004 rulliner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 23 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JAN Physician USIMANO thon 10 2008 /Medical 4c. County of Death acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ned le Surviv A3h If Under 24 Hrs. If Under 1 Year al Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F 214-62-1539 54 JUN 7 1953 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 XNo "natural", or Items 23a or 28a-f st idical Examiner must be notified Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2139 Howard Road 21061 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 N Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Construction and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Anthony Cusimano George Dorothy Μ. Corame Baltimore, Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Anthony D. Cusimano- Son 1428 Ticker Lane, Crownsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc. 1/18/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H Cremation Society of Maryland, 299 Frederick Road, Baltimore, Williams YU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Heart **Physician** clerotic /Medical **Examiner** Se wentially list conditions Se uentally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examine attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 ∠Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2.X.No certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) T_o 1 Yes 2[] No 2 ZR/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 X Vatural 5 ☐ Pending investigation Injury 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number d cause of death (Item 23a) (Type, Print) 30. Name and address of person who co ones mo 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

S NAL

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1/20/2008 Pay **Physician** 6:00 P M Rita G. Cinnamond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 215 Belmont Forest Court apt # 302 Timonium If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 1 ¥ F Maryland Director 219-20-6900 81 8/31/1926 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Timonium MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21093 215 Belmont Forest Court apt # 302 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black White etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home +4 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Marie Ralston John Paul Guckert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar important: if item 27 is any Injury or other trau 65 Luzern Lane Tell City, Indiana 47586 Mary Jo Borders / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/26/2008 |Baltimore, Maryland Most Holy Redeemer 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service License 1050 York Road Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final urosepsis **Physician** 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): cerebrovascular accident **Examiner** 21/2 4 ears Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perforr 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ospital or Attending Phours after death.
Ineral Director: After it filled in by the funerar After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Registrar DHMH 17 Rev 1/2001

State

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, 1

OV

Year)

29c. License number

052008

601 N. Caroline St. Baltimore MD 21287

January 22, 2008

and manner stated.

32. Registrar's Signáture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Protopowicz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #11, perInf g881 7/25/Gertificate of Death Reg. No. 🥎 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 18 Month Year **Physician** UnlA 2008 MAYNE PANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner A BAI Timore ORCC If Under 1 Year | If Under 24 Hrs. 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1**X**M 2□F Months Days -68-2195 Director OCTOBER 11,185 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ØYes 2 ☐ No Director BAITIMORE 10f. Zip Code 2/206 10g, Citizen of What Country? 10e. Street and Number 5544 FORCE .5, by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ould be filed within 72 hours after (Mental Hygiene. 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Saltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Boiler Engineer BAITIMOR OGRAde NONE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SARRETI UNIAP 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informart's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr any injury or other traurr once. RD. ApT. H. 2 DODNOW BA110. M mitchel A 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 ☐ Removal from State BAITIMORE, WIL An. 26.2008 4 Donation 5 Dother (Specify) 21. Signature o Funeral Service Licenses 22. Name and Address of Facility N. CAROLINEST. BA Bests Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OF **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner use as the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has bage 2 s autopsy performe certificate 1∐ Yes 2 To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural
2 □ Accident Injury 1 ☐ Yes 2 ☐ No after death. death. the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2008

State Registrar

31. Date filed (Month, Day, Year)

JAN 23 2008

LEDAMUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day (**Physician** D orsey 9:40 AM joseph 2008 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore HOSPHAI Ballimore Harbor Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 □ F 75 212-30-9119 Director 7-17-1932 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Show r 28a-f show notified at XXYes 2 ☐ No **Funeral Director** Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be 1 United States 21122 236 New York Ave. 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 years College (1-4or 5+) 2 vear **BGE** Supervisor years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Smith Charles Dorsey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 236 New York Ave. Pasadena, Maryland 21122 Etta Dorsey (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 1-23-2008 Baltimore, Maryland Bayview Crematory 21. Signatur of Fune Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd Pasadena, MD 21122 Wayne Osterling Approximate Interval Between Onset and Death se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause on each line. 23a. art1. Enter Enter ne dise or hea failure Immediate Cau — (Final disease or condition resulting in death) Pheumohia Physician 20 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unitary that initiated events resulting in death) Last Due to (or as a consequence of) Examine rsician and The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ hyperlension. dementia 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown Completed cerebrovascular 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy perform Hospital or Attending Physician: after death. Director: After this certification by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA P 1 Tyes 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: (Month, Day Year) , + Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2

Michelle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIM

3001

32. Registrar's Signature

To the

S. Hanover

29c. License number

St .

29d. Date signed (Month, Day, Year)

Baltimore, MD 21225

January 21,2008

ician	Decedent's Name (First, Middle, Last	LORETTA AGNI	ES DAI	LEY	-	2. Date of Deat Month	Day Ye	3. Time of Death 5', 00 P M
dical niner	4a. Facility Name (If not institution, give Baltimore-Washing	,	nter		r Location of Death		4c. County of E	
al or	5. Social Security Number 6. Se 220-07-2345			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 24,	Year) 9.	Birthplace <i>(St</i> ate or Foreign Country) Maryland
tor	Usual Residence of Decedent 10a. State Maryland N/A Ann	e Arundel 10c. City	, Town or Lo	cation Glen I	Burnie			10d. Inside City Limits
al Director	10e. Street and Number 313 Hosp	ital Drive stend Street	-	10f. Zip Code - 2123	21061 0	1	0g. Citizen of Wha	t Country?
by Funeral [11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White
Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+)	(Give life.	DO NOT use retire	during most of working	lg	Mo Uon	_{ess/Industry} Movie Theater
a	10 17. Father's Name (First, Middle, Last) Michae	0	(Clerk	18. Mother's Name	(First, Middle, I	Maiden Surname)	Hovie illeater
-To	19a. Informant's Name/Relationship (7) Helen V. Aburn				Cather and Number or Rura iel Mudd Ro	Route Number	; City or Town, Sta	
	20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 □ f	20b. Pl.	ace of Dispo	osition (Name of matory or other pla	ce) D	ate	20c. Location - City	or Town, State
ouce.	4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens	see Kevin E Eck	er 22	2. Name and Addre	alunials E.	novol E	Iomo D A	e, Maryland
al Examiner	23a. Part f. Enter the disease, or comp shock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to minimulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of):	Pieu	monia	тезриасту ап		Approximate Interval Between Onset and Death
Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	death 3[⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date o	f delivery Day Year
by	Part II. Other significant conditions co	ntributing to death but not resu	Iting in the u	nderlying cause giv	ven in Part I.	23e. Did tol		te to the cause of death? Probably 4 Unknown
Completed						24a. Was a autops perform 1∐ Yes	sy / prio	
To Be	T res 2 No		ER/Outpatier		4 ☐ Nursing Hor	ne 5 Reside	ence 6 Other (Specify)
Certification:	27. Manuar of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 2 Homicide 2 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At hose building, etc. (Specify		M 1 □	Yes 2 □ No			or Rural Route Number,
Medical C		rsician: To the best of my know iner: On the basis of examinat and manner stated.						
1 20	29b. Signature and title of certifier	Wich III	14 N	29c, Licens	e number 1365		Januar Burr	Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrer	State of Ma		ertificate of I		d Mental Hygi	ene g. NG: 008	01196
	Physic /Medi		Decedent's Name (First, Middle, Last) JESSIE		VISON				18°, 2008°	3. Time of Death 2:58P M
1	Exami	ner	4a. Facility Name (If not institution, give str Presbyterian Home o	Marylan		4b. City, Town, or TOWSO	n		4c. County of Dea Balti	more
	Funeral Director		5. Social Security Number 215-01-7001 Usual Residence of Decedent	7. Age 97	(In yrs. last birthda) Yrs.	Months Days	If Under 24 H	8. Date of Birth (Month, Day, Pril 29	, 1910 Ma	thplace (State or Foreign ountry) ryland
	Maryland a-f show	tor	10a. State 10b. County Maryland Baltimore		10c. City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes → ☐ No
	ath with the Marylar 123a or 28a-f show ust be nutified at	al Direc	10e. Street and Number 400 Georgia Court			10f. Zip Code 212	204	10	g. Citizen of What Co	
900	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. ?? Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Exercities : ust be notified at	Completed by Funeral Directo	11. Marital Status 12 1 Never Married 2 Married XX Widowed 4 Divorced	Was Decedent Ev Armed Forces? 1 Yes 2 Who If Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? In, Mexican, Pu Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	30	ompletec	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Giv life.	edent's Usual Occupi e kind of work done d DO NOT use retired Administra	during most of v	working	6b. Kind of Business	^{/industry} Marvland
Maryland 2	uld be filed Aental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Jesse Small			14 TO 16 TO	18. Mother's N	Name (First, Middle, M Elsa Baist	laiden Sumame)	nar y rama
	and 2 shou alth and M 27 is ma er trauma		19a. Informant's Name/Relationship (Type Grace E Honeywell	Print)				Rural Route Number, Baltimore		
Baltimore ,	Elementary/Secondary (0-12) College (1-4or 5+) Administrative As							n 28,2008 Mitchell-Wied	efeld Funera	Pennsylvania 1 Home Inc
	rnysician /Medical		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)			Approximate Interval Between Onset and Death				
8760,	rate be executed whysician and hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course Office Off							
P.O. Box 687	ath certific attending p for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	ivery Day Year
	juires that the de n signed by the a lid be detached t	by	Part II. Other significant conditions contri	outing to death but	not resulting in the (underlying cause give	en in Part I.		acco use contribute to	the cause of death?
al Records,		Completed						24a. Was an autopsy perform 1 \sum Yes 21	ed? 24b. Were at prior to death?	itopsy findings available completion of cause of
Division of Vital	ding Ph h. After th funeral	Certification: To Be	2 Accident investigation	1 Unpatient 28a. Date of Injury (Month, Day)	/ - At home, farm, st	of 28c. Injury Work M 1 \(\square	ar: 4 🗷 Nursing	Death (Check only one) Greath (Check only one) Greath (Check only one) Beath (Check only one) 28d. Describe how 28d. Describe how 28d. Location (Street only one)	nce 6 Other (Spe vinjury occurred	
Q	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier (Check only (Ch	On the basis of e	xamination and/or in	th occurred at the tim	e, date and pla	ace, and due to the cau	use(s) and manner as	s stated.
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner state	d.	29c. License	number	29	d. Date signed (Mont	
•	2		30. Name and address of person who comp	leted cause of dea						4,002/2019
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s Signature		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-5 - 7 5	1 01 110	1 0 0,27

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 4 15AM Dusch Jan 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMIRE REIJAB BALTIMORE CARE CENTER EXTENDED 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1[XM 2□F Months Days Hours Min. Maryland Director 218-28-9605 June 10,1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f sh notified a 1 ☐ Yes 2 XNo Dundalk Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe pe 21222 USA 3615 Wheelhouse Road "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 years Forklift Operator Auto Parts item 27 is marked other other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Johanna Uhl Michael Duschl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Duschl Wife 3615 Wheelhouse Road, Dundalk, MD. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Janűäry 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Memorial Cron Middle River, MD. 24,2008 21. Signature of Funeral Service Licensee connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner and that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, physician s the buria Physician/Medical as guipt IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 0 in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page perform certificate or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural ours after death, neral Director: Air filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours after within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

8

Registrar

DHMH 17 Rev 1/2001

Raven

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shandely q

SURIZIH

31. Date filed (Month, Day, Year)

3900

Registrar's Signature

Lich

052739

Blud Baltimore

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Donald. 12:43 AM Ray Dear January 18 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Union Memorial Hospital Baltimore N/A5. Social Security Number 6. Sex 14 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 212-36-9563 OCT 3 1940 Director 67 Mississippi Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 No Director MD N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or dical Examiner must be r 1608 E. 31st Street 21218 USA 14. Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Worker Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK Dorothy ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2856 E. Federal Street, Baltimore, MD 21213

of Disposition (Name of Date 20c. Location - City or Town, State Helen Cook - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 1/21/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, mul 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Kespiratory | metabolic audosis Physician resulting in death) /Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed HIV / AIDS that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performe certificate ! 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending in 24 hours after death.

ie Funeral Director: A pletely filled in by the fu within 24

State

Registrar

Medical

31. Date filed (Month, Day, Year)

MAURICE

3

29b. Signature and title of certifier

29a. Certifier

(Check only

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHEPPARD, M.D. Union Memorial Hospital, mo. 32, Registrar's Signature

2

, MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

AT 243 8946-H3

DHMH 17 Rev 1/2001

State

Registrar

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day William N. Diggs 1 2008 7:20 p.M 14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Future Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-24-1927 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F MD Director 80 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2 ☐ No Director Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21216 2725 Walbrook Avenue Apt 710 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. fy Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosie Alston James E. Diggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815 N. Milton Avenue Baltimore, MD 21205 Yvette Price-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State tp☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/25/2008 Owings Mills, Garrison Forest 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H East North Avenue Balto, MD 21202 1101 23a. Part : Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronny disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a conservence of Physician/Medical Examiner day, leading to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1🙇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYSICIAN

Registrar
DHMH 17 Rev 1/2001

State

W. BALTIMORE ST, BALTIMORE, MARIAR

1940

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Virginia Elizabeth Elliott ŽŽ 2008 January 11:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 72 Crimson Avenue Taneytown Carrol1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Country)
MD 216-22-2513 Sept 8 1927 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or nust be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MDCarrol1 Taneytown 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 72 Crimson Avenue 21787 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ white 3 € Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 17. Father's Name (*First, Middle, Last)*William W. Cole 18. Mother's Name (First, Middle, Maiden Surname) Be W. Cole Alice Elizabeth Brandenburg P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrence L. Jett (son) 636 Drain Dr. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page.
Department o
Important: If i
any injury or
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 1-26-08 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License ▶ Page Haight > erbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) - burnay 1 -0 **Physician** vertibun ADENO CARLINOWA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown care nas been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MASS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown REMI Failur Hent Congestive 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 ☑ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and D43643 1-22-08 47. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick St. TANENTOW MID 21787 TATE, M. D Asou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan					- 1	nno	01202
			State Registrar 1. Decedent's Name (First, Middle, Last)	1	Cei	rtificate of	Death		Reg. No.	JUO	01202
	Physici	an	T. Decedent's Name (First, Middle, Last					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give	Gregory	Ever	4b. City, Town, o	or Location of I	Death	13	2008 ounty of Death	6:00p
1	Exami	iei	ll09 Ellamont					304			
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	Baltin If Under 1 Year	If Under 24		th	9. Birthp	place (State or Foreign
	Director		218-86-1854	¶M 2□F 46	Yrs.	Months Days	Hours	Min. (Month, Da	.1961	Cou	1D
	and *		Usual Residence of Decedent 10a. State 10b. County	10c Cit	v. Town or Lo	cation				1	10d. Inside City Limits
	Manyt f sho	ŏ	MD								1 CXYes 2 No
	the 28a	Director	10e. Street and Number	N/A E	Baltin	10f. Zip Code			10a, Citize	n of What Cour	ntry?
	13e or		1100 811			212	1.6				46
	ours after death with the Marylar ret', or tems 23e or 28a-f show Examinat out the notified at	Funeral	1109 Ellamont 11. Marital Status	Street 12. Was Decedent Ever in U. Armed Forces?	S. 13.			n? (Specify Yes or No Puerto Rican, etc.)		S A Race - Amend	
9	or Ite		Never Married 2☐ Married	1 Yes 2 No		1 Tes, specify Cub 1 □ Yes 2 및 No		ruento Hican, etc.)		Black, White,	
00	72 hours neturel', lical Ex.	d by	3 Widowed 4 Divorced	Year or Dates:						BTS	
21215-0036	within 72 hours after death with the Maryland ene. then "returet", or Hems 23e or 28e-f show the Markeal Examinat must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of	f working	16b. Kind	of Business/In	dustry
212	d with giene.	ошь	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+) N/A					E&S	Contr	acting
b	the Hyg	Be C	17. Father's Name (First, Middle, Last)	N/A	——HOII	e Impro	18. Mother's	Name (First, Middle,	Maiden S	ımame)	
/lar		To E	Thomas Everett				Mari	e Willia	me		
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street		or Rural Route Numb		own, State, Zip	Code)
	and ealth m 27		Marie Everett-			0 Easth	oury A		alto		1206
Baltimore,	e = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		lace of Dispo emetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Loca	tion - City or To	own, State
ţ	t. Pag rtment rtant: If		* 4 Donation 5 □ Other (Specify)	Mt	Zion	Cemete	ry 1-	19-2008	Lan	sdowne	, MD
Bal	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licens		22	. Name and Addre		March F			
*.			23a. Part1. Enter the disease, or compl	cations that caused the death	Do not ent	TTOT	E. No	rth Aven	ue B	alto,	MD 21202 Approximate
R	Db!-!		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.					11031,		Interval Between Onset and Death
	Physician /Medical	ĺ	disease or condition resulting in death)	Due to (or as a consequ	ience of:	el fo	il ill	-			
	Examiner			540 to (01 a3 a consequ	201109 01).	U					
		ner	Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequ	eride Uty:			_			
J	ocuted nd transi	Examiner	that initiated events								
30,	cate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	death certificate be executed eattending physician and ed for use as the burial-transit	dical			_					_	
9 x	attending programment for use as	by Physiclan/Me	IF FEMALE:	3c. If yes, outcome of pregna	ncv					d Bara of delice	
Вох	atter affor u	clar	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		230	d. Date of delive Month	Day Year
P.O.	the che	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
	The faw requires that ate has been signed b bage 2 should be deta	y P	Part II. Other significant conditions con	tributing to death but not resu	alting in the ur	derlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to th	ne cause of death?
Records,	w require been sig should b	edt	Conc	lio myr po	the/			_ 10`	/es 2 🗆 I	No 3 Prob	ably 4 Unknown
ecc	law re as be 2 sho	plet			8			24a. Was			psy findings available
		Completed						— autop perfo 1 ☐ Yes	rmed?	death?	mpletion of cause of 2□ No
Vital	cian: ertific ector,	Be (25. Was case referred to medical examiner?				26. Place of	Death (Check only o			· · · · · · · · · · · · · · · · · · ·
	Physi this c al dire	P	1 □ Yes 25 No	ospital: 1 Inpatient 2 I			4 Nursi	ng Home A Resid			y)
Division of	Jing F	Certification;	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	k?	28d. Describe I	now injury o	ccurred	
S	Attended death ctor:	lical	2 Accident investigation 3 Suicide 6 Could not be	28e Place of triury - At ho	me farm etro		Yes 2 □ No	29f Location (6	Stroot and A	lumbar or Rum	I Route Number,
<u>S</u>	after after Dire	erti	4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)	et, factory, office		City or Tox	vn. State)	diliber or Aura	i noute ivatiber,
			29a. Certifier 1 Sertifying Phys	ician: To the best of my know	wledge, death	occurred at the tin	ne, date and p	lace, and due to the	cause(s) an	d manner as st	aled.
	he Ho n 24 he Fu	Medical	(Check only 2 Medical Examir one)	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my o	pinion, death o	occurred at the time,	date and pl	ace, and due to	the cause(s)
	Vith vith Com	Σ	29b. Signature and title of certifier	0 111	1.	29c. Licens	e number		29d. Date s	signed (Month,	Day, Year)
			* Ellink	1 /all	Mil	2 00	DV9	}	01,	116/08	
	2		30. Name and address of person who co	mpleted cause of death (Item	230 Hype, F	Print)	B. 11	7 B21	1	4.	20 /
	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signat		0/,	1941	1 1021	<i>/</i> ·	der	
	Stat Registra		JAN 2 3 2008	Also As As	A	W .					

Division or Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans as for use ed by the a cate has been sig., page 2 should b certificate has funeral director. After this 24 hours after death. filled in by the Hospital

Funeral

Director

r 28a-f show

"natural", or items 23a or adical Examiner must be r

the Medical

Department of Heatth an Important: If item 27 is any Injury or other trau once.

Physician /Medical

Examiner

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Medical within 24

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifie

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON POH LIM. TOWSON. MARYLAND 21204 M. D. 7601 OSLER DRIVE.

D37254

31. Date filed (Month, Day, Year) JAN 23 2008 32. Registrar's Signature 12 30000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Wesley 19,2008 2:28p /Medical Easton January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6110 <u>Bessemer</u> Avenue 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F Months 53 Yrs. Director 10-31-1954 218-64**-**2552 Maryland Usual Residence of Decedent r 28a-f show notified at 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD N/A<u>Baltimore</u> 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 6110 Bessemer Avenue 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

Is marked other than "natural", or iten 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 7 is marked other than "natural", traumatic event, the M. dical Exa 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A<u>Security Guard</u> <u>Abacus Corp</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Wesley Easton Phyllis M. Isaac 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun once. Peggy L. Easton - Wife 6110 Bessemer Ave. Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Jan21,08 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Solvice Licenses 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Urothe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner -OYONGIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed 450 as the burial-trar Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1∐ Yes 2⊠ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Hospital or Attending Plants after death. 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🔀 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral D Hospital 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0024303 01/21/08

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

Esstern the

21224

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Luhay M 31. Date filed (Month, Day, Year)

JAN 23

3509

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) **Physician** Sharon Fitzpatrick /Medical Examiner Can Blin Social Security Number **Funeral** 214-88-2528 Director 3a or 28a-f show t be notified at 10a State Md. Director 10e Street and Number ms 23a Funeral "natural", or items 11 Marital Status Maryland 21215-0036 Completed by traumatic event, the Medical 8 yrs. t and 2 should be fill Health and Mental H tem 27 Is marked oth Be other t Baltimore, ortant: If item ? Injury or other Pages 1 Department or Important: If any Injury or permit. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner**

1 21, 2008 4c. County of Death January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rosedale ital Center Square Ho If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 □ M 🎾 F Nov. 16, 1961 Md Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits Baltimore 1 Yes 2 No Fort Howard 10f. Zip Code 10g. Citizen of What Country? 7507 Oak Ave. PO Box 351 21052 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Pilkerton Doris M. Arthur 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Fitzpatrick husband 7507 Oak Ave. PO Box 351 Balto. Md. 21052 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 23, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 23a. Part1. Enter the disease, or complications that caused the death. In not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Approximate Interval Between Onset and Death Lung Cancel Stage month cell non-small IV Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 m hths? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed? Yes 2 No certificate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 3 ☐ DOA 2 ER/Outpatient Certification: To Division or this 27. Manner of Death 1 ■ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in 24 hours the Funeral Directory The Filled in by 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature ar VASILIADES, M.D 1/21/2008 DOOG4755 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore, MD, 21237 OR Minus 31. Date filed (Month, Day, Va

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Month

3. Time of Death

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day **Physician** Tauva. Th 2008 /Medical on la Gin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex 401 enter Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 71 Yrs. If Under 1 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2**Y**☐ F Months Davs Hours Min 219-32-6810 Director MD Feb 16 1936 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MDBaltimore Director 1 □Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any liury or other traumatic event, the Medical Examiner must be. 8311 B Mindale Circle 21244 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 T If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 ☐ No Specify. Specify: white þ 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) clerk & typist Administration 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Sergent Wells Ester Irene Sherman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Fauver (daughter) 8311 B Mindale Circle, Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Woodlawn Cemetery 1-23-08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Dauge Haight > P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): Due to (or as a for equence of): COLIL Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No performed 1∐ Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA

Physician /Medical Examiner

3altimore, Maryland 21215-0036

Pages 1

sician and burial-trans attending physician the nse for ed by the a detached f pe peen has page 2: certificate

The law requires that the death certificate be executed this After i To the Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

Certification:

Medical

State Registrar

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number

130056623

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Comme 31. Date filed (Month, Day, Year) 32. Régistrar's Signature 2 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician Berhamme Foster A Fally Name (if not institution, yet arrest and number) A Fally Name (if not institution) A Fally Na	ce (State or Foreign) y I vania I. Inside City Limits 1 Yes 2 No y?
## Againty Name (If nor arbitulous, pive street and number) ## Againty Name (If nor Arbitulous, pive street and number) ## Againty Name (If nor arbitulous, pive street and number) ## Againty Name (If nor arbitulous, pive street and number) ## Againty Name (If nor Arbitulous, pive street and number) ## Againty Name (If nor Arbitulous, pive street and number) ## Againty Name (If nor Arbitulous, pive street and number) ## Againty Name (If nor Arbitulous, pive street and number) ## Againty Name (If nor Arbitulous, pive street number) ## Againty Name (If nor Arbitulous, pive street number) ## Againty Name (If nor Arbitulous, pive street number) ## Againty Name (If nor Arbitulous, pive street number) ## Againty Name (If nor Arbitulous, pive street number) ## Againty Name (If nor Arbitulous, pive street number) ## Againty Name (If nor Arbitu	ce (State or Foreign) y I vania I. Inside City Limits 1 Yes 2 No y?
Funeral Director The content of t	ce (State or Foreign) y I vania I. Inside City Limits 1 Yes 2 No y?
10a. Saie 10b. County 10c. City, Town or Location 10c. Toky, Town or Location 10d. 20c. Location 20c. Location 10d. 20c.	1 ☐ Yes 2 2 1 No y? In Indian, c.
Education The property of t	n Indian, c.
Education The property of t	c. e
Education The property of t	stry
20a. Method of Disposition 1	
20a. Method of Disposition 1	
Chesapeake Crematory 1/22/2008 Beltsville, 1 Due to (or as a consequence of):	ode)
Physician Medical Examiner Page 1 19 19 19 19 19 19 19	
Physician Medical Examiner Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) The property of the property	pring, MD
23d. Date of delivery worth to the past 12 months? 1	Approximate nterval Between Onset and Beath
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the significant conditions contribute to the s	/ Day Year
24a. Was an autopsy prior to complete the complete to the complete the	S /
25. Was case referred to medical examiner?	sy findings available pletion of cause of
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)	
To be a significant of the control o	
building, etc. (Specify)	
29a. Certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, D	Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, D 29d. Date signed (Month, D 20d. Date signed (Month, D	ted.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amir Arsalan Mirza Alikhani, MD; 11701 Livingston Road; Fort Washington, N	ted. he cause(s) ay, Year)
State Registrar Registrar All I Arsalan Mirza All Rhani, Mb, 11701 Livingston Road, 1012 washington, 1	ted. he cause(s) ay, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY 13 2008 7:52 PM **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Sept. 24,1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Maryland 1 ☐ M 2 ☐ XF 85 214-14-0394 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 3√☐ No Director Baltimore Towson Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21286 USA 15 Treeway Court 1D Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2[XNo 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify: 21215-0036 White Completed by 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Blue Cross/Blue Shield Clerical 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be and 2 should be fi lealth and Mental H Department of Health and Mental Important: If Item 27 Is marked of any Injury or other traumatic ev Mary Vavra Poskocil John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21234 3245 Woodrine Ave. Mrs. Mary C. Smith / Niece Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Timonium, Maryland 1/23/08 Dulaney Valley Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 La 23a. Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lift only life cause on each line. Approximate Interval Between Onset and Death BRADYC Immediate Cause (Final MINUNT **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): IL MUN MOU mbouson Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine physician and s the burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 □ No 3 ☐ Probably 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Injury 5 Pending investigation 1 Tyes 2 No after death. 2 Accident the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined filled in by 4 Homicide Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PMPIUMN ATTEMPING

Registrar
DHMH 17 Rev 1/2001

State

GBMI

6701 NCHARUSIST

m

32. Registrar's Signature

at the said

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

VOLTAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year Demetrius 00:03 AM 2008 /Medical POVEN 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Johns pkins tospita Year | If Under 24 Hrs. 10 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 213-98-6181 Months Days Hours Min 1**1** M 2 □ F 26 Director July 27, 1981 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show at er than "natural", or items 23a or 28a-f shifted, the Medical Examiner must be notified Director **Baltimore** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Laurens Street Apt. 1A 21217 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: African American þ 1 ☐ Yes 2 XXNo Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Transportation Blaock Top Baltimore City permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygis Important: If Item 27 is marked other i any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Horsey Rosalind E. Figgs ို 19a. Informant's Name/Relationship (Type. Print) Rosalind E. Figgs / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 Laurens Street; Baltimore, MD 21217 (Apt. 1A) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Zion Cemetery 01/26/2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, MD 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator Physician distress /Medical Due to (or as a consequence of): Examiner ulmongry metastase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit medullary Carcinon enal Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: detached for use If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes A No 24a. Was an autopsy perform 1∐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed thours after death. this certificate after death Director: within 24 hours a To the Funeral L completely

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Stree 600 Norsh Wolfe 31. Date filed (Month, Day, Year) 32. Registrar's Signature ZUUO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

-00C

Marylan

29d. Date signed (Month, Day, Year)

3008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and Mertificate of Death		ene g. No.2008	01210
	Physici	an.	Decedent's Name (First, Middle, Last)		Date of Death Month		3. Time of Death
	/Media	cal	BETTY JEAN GRAY	14.07.7	JANUARY	17, 2008	2:08P M
	Examin	ner	4a. Facility Name (If not institution, give street and number) 5410 TINKERS CREEK PLACE	4b. City, Town, or Location of Death CLINTON		4c. County of Death PRINCE GI	EORGES
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (Month, Day,	9. Birthol	ace (State or Foreign
G. T.	Director		238 66 6795 G6 Yrs. Usual Residence of Decedent	monate Baye House Ham		1941 NORTH	
	yland now at		10a. State 10b. County 10c. City, Town or L	ocation		10	Od. Inside City Limits
-	8a-f sl	Director	MD PRINCE GEORGES CLINTON				YXXYes 2□No
4	a or 2		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Coun	
4	ms 23	Funeral	5410 TINKERS CREEK PLACE 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20735 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	UNITED STAT	
စ္က	r z nours arier deam with the maryland "natural", or items 23a or 28a-f show kdical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X2X No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:	Rican, etc.)	Black, White, e	
5-0036	tural", al Exa	ed by	3XXWidowed 4 □ Divorced Year or Dates:	edent's Usual Occupation		6b. Kind of Business/Ind	
رن ا	witilit /2 ene. than "na he Medic	plete	(Specify only highest grade completed) (Give	e kind of work done during most of worki DO NOT use retired)	na	FEDERAL GOVE	
N 3	Hygiene Hygiene other tha ent, the	Completed		JREMENT SPECIALIST	I	IBRARY OF (CONGRESS
		Be	17. Father's Name (First, Middle, Last) B. CHAMBERS	18. Mother's Name		,	
5	and Mental is marked raumatic ev	ြင		ing Address (Street and Number or Rura	HARTGRO		Code)
ž ,	and cleath a m 27 is her trau		The state of the s			IL, NC 2807	
בַּ			20a. Method of Disposition XIX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposerery, cre	osition (Name of Dematory or other place)	ate 2	Oc. Location - City or To	wn, State
Saltimor	- + # ÷		4 □ Donation 5 □ Other (Specify) FORT LINC	COLN CEMETERY 01/26		BRENTWOOD,	
מ מ	Depar Impor any ir		21. Signature of Pulleral Service Licensee	22. Name and Address of Facility 1ARSHALL S FUNERAL 1308 SUITLAND ROAD	HOME OF	MARYLAND, IN 10, MD 20746	IC.
P			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate course from the dry of the course from the dry of the course from the dry of the course from the co				
	und transit	Examine	Cause (Disease or injury that initiated events c.				
5 8	bur	al E	Due to (or as a consequence of):				
Octificate	g phys	edical	d				
XOC F	this certificate has been signed by the attending pal director, page 2 should be detached for use as it	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of deliver	,
The law requires that the death	the at	ysici		Other (specify)		Month	Day Year
r ted	ned by detac		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
de law requires	en sign	ed by			1 ☐ Yes	x R No 3 □ Proba	ably 4 Unknown
	las be	Completed			24a. Was an autopsy		sy findings available apletion of cause of
ב ב ב	icate h				performe 1 Yes 2	ed? death?	2 □ No
VICAL	s certif lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	****		
	ter this	\vdash	27. Manner of Death 28a. Date of Injury 28b. Time of	THE SILL BOA 4 INUISING HOR	8d. Describe how	ce 6 Other (Specify injury occurred)
S C C	eath. Ior: Af the fu	catio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Z Z	after d Direct I in by	Certification:	4 Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	8f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
DIVISION OF VICE	within 24 hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place, a	and due to the cau	use(s) and manner as sta	ated.
the Ho	the Fu	fedical	one) and manner stated.				
L.	Wit]	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, I	
	10		30. Name and a Tress of person who completed cause of death (Item 23a) (Type,	Print)	(30/81/16	
	10		DONA (ESKUSKI DO 9200 &	Print) HOGOGS DOSILCT, Large	MD		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
1	Registr	aı	JAN 2 3 2008 12 19 19 19 19 19 19 19 19 19 19 19 19 19				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year 2008 Mary Jane Getka anvary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospita Baitimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06/25/1921 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 7 € 215-14-5658 86 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f sh notifled 1 Nes 2 No Maryland N/ABaltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or any or other traumatic event, the Medical Examiner must be r 222 Stonecroft Rd. Apt. H 21229 United States Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 Plant Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Herbert Mary Kennedy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222 Stonecroft Road Apt. H Paltimore, Maryland 21229 Milton S. Getka / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 01/26/2008 Baltimore, Maryland Holy Redeemer 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility David J. Weber Funeral Homes PA 21. Signature of Funeral Service Licenses 5311 Fdmondson Avenue Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Arterio scleratio asolar 1/n Kneun Coronary resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician Completed by Physician/Medical attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 4□Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably ypercholesterolemia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 2□Nô 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 1 🔲 Inpatient 27. Manner of eath 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ✓2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Liet-Ka, Many Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Medical

29a. Certifier

JAN

State Registrar

29b. Signature and title of certifier

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

900 Coton home Biltimore Marylond

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day,

32. Registrar's Signature Year) 3 2008 2 3

			1- State of Maryland / Department of Health are Registrar Certificate of Death	, ,	Jiene Reg. No.	01010
		×	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 2000	3 Time of Death
•	Physicia /Medic		John Michael Gallus, Di	Januar	Day Year y 18, 2008	5:18 A M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	Death	4c. County of Dea	th
8			Stella Maris Hospice Center Timonium		Baltimo	
State of	Funeral Director		5. Social Security Number 219-26-9590 6. Sex 1 I M 2 □ F 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 1 If Under 1 Year 1 If Under 2 And In Under 3 And	Min. 8. Date of Birth (Month, Da) Feb. 1	9. Bir (, Year) 9. Bir (Co. 1, 1937 Ma	hplace (State or Foreign ountry) ryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	le Maryl Ba-f sho stified a	ctor	Maryland Baltimore	Dundal	ζ	1 □ Yes 🗷 No
	a or 2	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	•
	leath	eral	5 Bayside Drive 21222 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Conference of the Conference		United Stat	
980	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must <u>be notified at</u>	by Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origing if Yes, specify Cuban, Mexican, 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origing if Yes, specify Cuban, Mexican, 12. Yes 2 No Specify: 1 Yes 2 No Specify:	Puèrto Rican, etc.)		e, etc. Thite
15-0	d within 72 ho giene. r than "natu the Medical	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	of working	16b. Kind of Business	/Industry
212		dmo	Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Steelworker		Steel Ind	ustry
þ	it it je	BeC		's Name (First, Middle,	Maiden Surname)	
/lar		To E	John Michael Gattus, Sr. Mary	y C. Schaet	fer	
, Mar	d2sh thand 7ism traum		19a. Informant's Name/Relationship (Type. Print) Mrs. Linda C. Gattus (Wife) 19b. Mailing Address (Street and Number 5 Bayside Drive 1			Zip Code) 222
Baltimore, Maryland 21215-0036	80		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp	Date 1/21/2008	20c. Location - City or Towson, M.	_
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Fune 7922 Wise Ave.			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as c shock, or heart failure. List only one cause or the fine.	cardiac or respiratory ar		Approximate Interval Between Onset and Death
V.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	2 ALEX		Offset and Death
	Examiner		Due to (or as a consequence of):			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter the property that initiated events b. Due to (or as a consequence of): Cause (Disease or injury that initiated events)			
10	scutec ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
68760,	ificate be executed g physician and as the burial-transit					
	= 0,6	ledical				
.O. Box	at the death cert by the attending stached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23c. If yes, outcome pf pregnancy 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)		23d. Date of de Month	livery Day Year
Q	that ed by deta	by Ph		23e. Did to	bacco use contribute t	o the cause of death?
ord	equires en sign uld be			1 1 1	/es 2□No 3□P	robably 4 X Unknown
Vital Records,	The law te has b page 2 st	Completed		24a. Was autop perfo		utopsy findings available completion of cause of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	of Death (Check only o	ne)	
Or	Phys this al dii	٦			dence 6 XIOther (Spe	ecify) HOSPICE
	fter	tion	27. Manner of Death 1 X Natural 5 Pending (Month, Day Year) 28a. Date of Injury 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 N		now injury occurred	
Division	il or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Number or Fi vn, State)	ural Route Number,
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C		d place, and due to the h occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
.	To th withir To th comp	Me	29b. Signature and lifte of cartifles 1 29c. License number	50-5	29d. Date signed (Mon	
	241		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			
	0			JM, MD 2109	3	
	Sta Registr	-	1 m x 1 ft 12 ft 13 ft 13 ft 1 m x 1			

JANUARY 18, 2008 5:18 a.m.

JOHN GATTUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylar		artment of H			giene No	008	012	13
	Physici		1. Decedent's Name (First, Middle, Last Antoinette France					2. Date of Dea Month January	Day	2008	3. Time of De 7:42a	eath M
	/Medic Examin		4a. Facility Name (If not institution, give Carroll Hospice Do			4b. City, Town, or Westmins	Location of Death		4c. Co Cari	unty of Death		
	Funeral		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 16	r, Year)	9. Birthi	place (State or F ntry)	[⊋] oreign
	Director		Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo	cation		Oct. 16	194		10d. Inside City	Limits
	e Maryla la-f sho	ctor	MD Carroll		kesvill						1 Tes 2	X No
	3a or 26 st be ro	ai Dire	10e. Street and Number 609 Blankner Road			10f. Zip Code 21784		1	10g. Citizer USA	n of What Cou	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinar must be notified at angles.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2∏ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White, pecify:whit	etc.	
Maryland 21215-0036	within 72 hou ene. then "neture the Mudical E	Completed	15. Decedent's Edi (Specify only highest grad		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing		of Business/In	dustry	
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Joseph Isabella		<u> </u>		18. Mother's Nam Josephin	_		rname)		
	nd 2 shoilth and N 27 is ma		19a. Informant's Name/Relationship (7) Patricia Gilman (6)			•	and Number or Run rs Rd., S					
Baltimore,	Pages 1 a iment of Heatant: If item jury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State Lot	cemetery, crei 1don Pa		ery 1-23-		Balti	more, M	ID .	
Bai	Departimonal important in any in once.		21. Signature of Funeral Service Licens Parish aight				ss of FacilityHai 195 Sykes				Chapel	
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ications that caused the deal ne cause on each line. a. Due to (or as a conset	n Per		£ .	or respiratory ar		Q	Approximate Interval Betwee Onset and De	
	Examiner	J.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conser								
Į.	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse								
3760,	ate be executed hysicien and the burial-transit	icai		d								
P.O. Box 68	Attending Physicien: The law requires that the death certifica croath. r death. ector: After this certificele has been signed by the attending ph by the funeral director, paga 2 should be detached for use as the state of the control of the contro	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1	al death 3	Ectopic pregnancy Other (specify)	,		230	d. Date of deliv	ery Day Ye	ar
	uires that signed to d be deta	d by PI	Part II. Other significant conditions of	ntributing to death but not re	L.	nderlying cause giv	en in Part I.	10	obacco use		the cause of dea	
Records,	The law requir ste has been si baga 2 should l	omplete						24a. Was autop perfo		prior to co death?	opsy findings avompletion of cau	/ailable use of
Vita	sicien: certific irector,	Be	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatie	nt 3 DDA Oth	26. Place of Deat	th (Check only come 5 - Resid	ne)	Hother (Case	~ 000C	HOUSE
on of	ling Phy After this uneral d	lon: To	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur	y at rk?	28d. Describe I			,,,,	
Division of Vital	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funers! Director: After this certificete has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	nome, larm, st		Yes 2 □No	28l. Location (. City or Tou		Number or Rui	ral Route Numbe	Θ <i>Γ</i> ,
	To the Hospitel or within 24 hours after To the Funerel Dirticompletaly filled in I	edicai C	29a. Certifying Ph (Check only one) 2 Medical Exam	reician: To the best of my kn iner: On the basis of examin and manner stated.	owledga deal ation and/or in	h oncurred at the til vestigation, in my o	ms, date and place opinion, death occur	and due to the red at the time,	nausa(s) ar date and pl	nd manner as lace, and due	stated to the cause(s)	
)	To the Comple	Me	29b. Signature and title of certifier	(- Galvisin	∩ 0	29c. Licens	se number		29d. Date :	signed (Month	Day, Year)	
	10		30. Name and address of person who of	& amiliary	21 577	MIPR AC	nemne	LAPSTM	ILNST	er m	ARULAN	4
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			5.0 5.11			7107	
DH	IMH 17 Rev 1/2		JAN 2 3 20	118 1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3 Time of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Patrick 05/5 AM L. Gereighty 8005 lanuary 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore Baltimore p. tal ot | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAY 23 1934 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 1 M 2 □ F 73 Louisiana 434-80-4154 Usual Residence of Decedent 10c, City, Town or Location 10a State 10h County 10d Inside City Limits 1XYes 2 No N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6300 Red Cedar Place, #303 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Educator Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Gereighty Marguerite Rost 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jareene Barkdoll - wife 6300 Red Cedar Place, #303, Baltimore, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 1/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams ^{22 Name and Address of Facility} Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acc ocaldial disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Completed by Funeral

Be

ပ

MD

Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

of Health item 27 I

Depertment of Important: If its any injury or o

Baltimore, Maryland 21215-0036

Examiner as the burial-trans and

attending physician

signed by the

certificate has

After this

within 24 hours after death To the Funeral Director:

filled in by

Be

2

Certification:

Medical

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be

Hospital or Attending Physician:

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Completed by

24a. Was an

autopsy performed

2 PN0

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of

2 No

death?

1 ☐ Yes

25. Was case referred to medical examiner?

5 ☐ Pending investigation

6 ☐ Could not be

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

Wheeding

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

4 ☐ Homicide 29a. Certifier (Check only

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTO MD 21211

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature, and title of certifier

1 Yes 2 No

27. Manner eath

atural

2 Accident

3 ☐ Suicide

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VILLUBEROL 31. Date filed (Month, Day, Year)

0 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Carole

BMIII

3

30. Name and address of person who completed cause of death (nem 23a) (Type, Print)

32 Registrar's Signature

aton

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician 9:30 pm Barbara B. Gore 16 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey House Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 XF S.C. Director 214-38-0131 67 5-18-1940 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10h Count 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at MD N/A Baltimore 1√2 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1512 Lester Morton Court 21205 Funeral U S USA

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: Black 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. Factory Worker Line Worker 10th grade N/A 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lester Gore 2 Lela Belamy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Keisha Gore - Daughter 1512 Lester Morton Court Balto, MD 21205 permit. Pages 1 and Department of Health Important: If Item 27 any injury or other th Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Purial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Cemetery 1-23-2008 Balto, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H 9 1101 E. North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Years Cano lun 9 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Ent. Tundening Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) slcian and burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Dav Year 4☐Pregnant at time of death Burbara 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performe performed? 1 Yes 2 No Vital certificate or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA HOSPICE After this ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 150 MD 24170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 NE FutanSt Bulfinore MD 150 MD Kichey Hospice 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-00470 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Derrick Gladden State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day January 17, 2008 **Medical Examiner** Derrick Gladden 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Funeral Director Months Days Hours Min 215-53-9726 09 1 X M 19 98 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show Baltimore items 23a or 28a-f shoust be notified at once. MD NA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21216 929 North Ashburton Street Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 2 X No ō Widowed If Yes, Give Year Divorced Yes 2X No specify: Specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) more, MD 21215-0036
Pages I and 2 should be filed within 72 I nent of Health and Mental Hygiene. College (1-4 or 5+) other than Student 3rd na 17. Father's Name (First, Middle, Last) it: If item 27 is marked other fraumatic event, i traumatic event, Michelle Oliver <u>Kerreen Gladden</u> 19a. Informant's Name/Relationship (Type, Print) Michelle Oliver-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, X Burial 2 Cremation 3 Removal from State King Memorial Park Ponation 5 Other Specify: Arbutus Memorial 5 21 Signature of Funeral Servide Licensee 22. Name and Address of Facility Physician failure. List only one cause on each line. /Medical a. Asthma Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transi Physician/Medical x AMENDED 20b,c per fh g875 1-23-08 vt UNPENDED IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) this certificate has been signed by the att director, page 2 should be detached for 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an autopsy After this certificate has performed' 25. Was case referred to medical 26.Place of Death (Check only one) Be lospital: 1 Other 4 Inpatient 2 V ER/Outpatient 3 DOA 1 ✔ Yes Nursing Home 5 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 V Natural Pending Yes 2 No

16b. Kind of Business/Industry School 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 929 North Ashburton Street, Baltimore? Md 20c. Location - City or Town, State Randallstown 1/24/2008 Arbutus, Md March F/H West
4300 Wabash Ave. Baltimore.
Pat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21215 Approximate Interval Between Onset and Division of Vital Records, P.O. Box 68760, tall or Attending Physician: The law requires that the death certificate be-23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 V No Yes No Residence 6 28d. Describe how injury occurred Certification: completely filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 17, 2008 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD, Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL **OCME**

3. Time of Death

0306 hrs

9. Birthplace (State or Foreign

MD

10d. Inside City Limits

1 X Yes 2 No

Country)

Black

U.S.A.

White, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Zechariah Lee Hallback

Zechanan Lee m		- For State	State	or Maryland /		ificate of De		Werttal IT			
Physicia		Registrar 1. Decedent's Name (First, Middle,Las	st)		modito or Bo			Re 2. Date of Deat	g. No.	3. Time of Death
Medical Examin	er	ZECHARIAH	тее на	T.T.RACK					Month January 11	Day Year	1346 hrs
234		4a. Facility Name (if n	not institution, given	ve street and number)		4b. Cit	, Town, or Lo	ocation of Death		4c. County of D	eath
		Johns Hopkin				Ва	timore				
Funeral		5. Social Security Nur	mber 6. S	ex 7. Age	(in yrs. las	st birthday) If U	nder 1 Year	If Under 24Hrs	. 8. Date of Birt		. Birthplace (State or
Director	-	220 25 26	.01 15	∑M 2 F	10	Yrs.	nths Days	Hours Min.			Country) MD
	H	220-25-26 Usual Residence of D	721	N Z F	18	115.		<u> </u>	NOV. 4	, 1989	MD MD
any	ŀ		b. County	1	0c. City, 7	own or Location	 				10d. Inside City Limits
		MD			DAT	(TITMODE)					1 X Yes 2 No
rrylan la-fs	ector	MD 10e. Street and Numb	er		BAL	TIMORE 10f.	Zip Code	-	10	ng. Citizen of What (Country?
or 28	<u>Pire</u>	2242					,				,
with the Maryland s 23a or 28a-f show a e notified at once.		3312 NOBL 11. Marital Status	E ST.	12. Was Decedent E	ver in II S		224	anic Origin? / Sr	pecify Yes or No-	JSA	merican Indian, Black,
ath v item	uneral	1 X Never Married	2 Married	Armed Forces?				Mexican, Puerto		White, et	
", or	ᄣᅵ	3 Widowed	4 Divorce	1 Yes 2 2	No	1 Yes	2 X No	specify:		Specify: E	BLACK
ars af tural	희			or Dates: only highest grade comp	eleted)	16a. Decedent's Us			work done	16b. Kind of Busine	
72 ho	et l	Elementary/Second		College (1-4 or 5-		during most of	working life. D	DO NOT use reti	red)		ŕ
1936 Thin 1969 Than	힘	12TH				FOOD HA	NDLER			FAST FO	200
5-0036 led within 7 Hygiene. other than	Completed	17. Father's Name (Fi	irst, Middle, Last)	L	1000 111		8.Mother's Name	(First, Middle, N	Maiden Surname)	
215 be fill htal H rked ent, 1	Be	TROY L. H	ATTBACK				- 1	APRIL O	WENS		
21 ould I Mer s mar	2	19a. Informant's Name			_	19b. Mailing Addr				ber, City or Town, S	State, Zip Code)
MD d 2 sho lth and n 27 is		APRIL OWE	NS/MOTH	ER		3312 NC	BLE ST	BALT	IMORE, N	4D 21224	
Te, land	- [20a. Method of Dispos				lace of Disposition (ematory or other pla		etery,	Date	20c. Location - Cit	
MOre, Pages I a nent of He ant: If ite		1 X Burial 2 4 Donation 5	_		e s	TRINITY		01/	10/2008	BALTIMORI	ONNELL ST. E, MD 21224
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	21. Signature of Fune				22. Name	ind Address o	of FacilityWES	19/2000 LEV CHΔ\	/IS, JR. 1	FMRT. HM
iii ii p p ii ii		11/18	slew/	hand		2007	_09 EZ	STIFFIN A	VE BAI	LTIMORE, I	MD 21231
Physician	\neg	23a. Part I. Enter the failure. List only	dise is , or com	plications that used t	he death.	Do not enter the mo	de of dying, su	uch as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval
/Medical	- 1	Immediate Cause (Fir		Gunshot wounds	(2) to h	nead and torso					Between Onset and Death
Examiner	-	or condition resulting		Due to (or as a consec	<u> </u>						
		Sequentially list cond									
	Ē.	if any, leading to imm cause. Enter Underly	ving Cause	Due to (or as a consec	quence of)	:					
11.	Examiner	(Disease or injury that events resulting in de		Due to (or as a consec	quence of)	:					
executed an and al - transi			d								
760, Sate be executed physician and he burial - transit	Medical	UNPENDED		AMENDED							
760, cate be physici	ğ	IF FEMALE:		23c. If yes, outcom	e of pregn	ancy				23d. Date of del	livery
687 ertific	an/	23b. Was decedent prepared past 12 months?	egnant in the	1 Live birth		2 Fetal de	ath 3	Ectopic pregna	ancy	Month	Day Year
Box 687 death certific the attending p ed for use as th	Physician/I	1 Yes 2 No	9 Unknow	4 Pregnant at t	ime of dea	5 Other (Specify)				
the de	훒	Part II. Other signific	ant conditions		but not ro	sulting in the under	dog cause div	ven in Part I	23e Did to	phacco use contribut	te to the cause of death?
P.O.	ā			contributing to dead	Datificite	salang in the under	ning cause giv	VOIT III T EIT I.			Probably 4 Unknown
duires	Completed								24a. Was		re autopsy findings available
Orc aw re as be 2 sho	휣								autop	sy prio	r to completion of cause of
Rec The I	팃								1 Yes	rmed? dea 2 No 1 ✔	Yes 2 No
ian: Sertifi ctor,	a	25. Was case referred examiner?						of Death (Check	only one)		
this c	o١	1 ✓ Yes 2	No	Hospital: 1 Inpatier	t 2	ER/Outpatient 3	DOA	Other Nursi	ng Home 5	Residence 6	Other:
Division of Vital Records, P.O. Box 687 spital or Attending Physician: The law requires that the death certificate has been signed by the attending I filled in by the funeral director, page 2 should be detached for use as the sidn of		27. Manner of Death	-	28a. Date of Injur (Month, Day, Ye Jan 9, 2008	y ar)	28b. Time of Injury	28c. Injury	at Work?	28d. Describe Subject sho	how injury occurred	
itend feath.	읥	1 Natural 2 Accident	5 Pending Investigation			2010 hrs	1 Ye	es 2 🗸 No	Cubject 3110		
VIS or A Offer of Direction by	<u>≅</u>	3 Suicide	6 Could no	28e Place of Init	ıry - At ho	me, farm, street, fac	ory, office bu	ilding, etc.	28f. Location (S		or Rural Route Number, City
Di pital cours a	Certification:	4 V Homicide	determine	(Specify) Alle	y				1500 block E.	33rd Street, Balt	imore, MD
				cian: To the best of my							
To the Hos within 24 h To the Fur completely	Medical			r:On the basis of exam and manner stated.	ination an	id/or investigation, in	my opinion,	death occurred	at the time, date	and place, and due	to the cause(s)
	Σ	29b. Signature and tit	tle of certifier	4 0			29c. License			1	(Month, Day, Year)
		fd	the &	1	an	2	O.C.M	1.E.		January 14, 2	2008
- iti	İ			completed cause of de							
4	_	Tasha Greenl	•	Assistant Medica			n Street, B	Baltimore, M	D 21201		
		31. Date filed (Month,		2008 32. Registrar	s Signatur	M. Angel	6				
Regist	ar		ANZ3	CUUU CONTRA	See 1	1					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

€.	2	0	0	8	0	-	2	2	0

VICI I	ard Olibert		1- For State Registrar	Cer	rtificate of		id Wichia		g. No.	
	Physicia	an/	1. Decedent's Name (First, Middle,				•	Date of Death Month	Day Year	3. Time of Death 0838 hrs
Mec	dical Exami	ner	Richard 4a. Facility Name (if not institution,	Gilbert		w, Sr. b. City, Town, o	r Location of I	January 17	, 2008 4c. County of Deat	
			8181 Old Mill Road	give siteet and number)		Pasadena	LOCATION	Jean	Anne Arunde	t e
	Funeral		5. Social Security Number 6	. Sex 7. Age (In yrs. la	ast birthday)	If Under 1 Ye		24Hrs. 8. Date of Birti	(MM/DD/YYYY) 9. Bi	rthplace (State or
	Director		225-32-3620	X _{M 2} F 78	Yrs.	Months Da	ys Hours	Min. 01/04/	1930 c	^{ountry)} Virginia
	any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	on				10d. Inside City Limits
		_	,		sadena					1 Yes 2 X No
	larylan 18a-fs aton	Director	10e. Street and Number	munder ras	/440114	10f, Zip Code		10	g. Citizen of What Co	
114.70	the M 3a or 2 otified	į	8181 Old Mill Ro	oad		211	22		U.S.A	
1	th with tems 2 at be n	Funeral	11. Marital Status 1 Never Married 2 Marri	12. Was Decedent Ever in U. Armed Forces?				? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
	ter dea	I.I.	37	1 Yes 2 A No	1	Yes 2 X N	o specify:		Specify: W	hite
	ours af atural camin	d by	15. Decedent's Education (Specif	or Dates:		t's Usual Occup			16b. Kind of Business	/Industry
	16 n 72 h nan "n ic. t E	sete	Elementary/Secondary (0-12)	College (1-4 or 5+)		•		ic rearda)	Hostins 0	Air Cond.
	-0003 d withi /giene. ther the	Completed	10 17. Father's Name (First, Middle, L	N/A	Serr	Employe		Name (First, Middle, M		All Cond.
	215 be file ntal Hy rked o	Be	Christopher	С.	Harlow		Addie			tout
	21 Should and Me is ma	2	19a. Informant's Name/Relationshi		1	,			ber, City or Town, Sta	
	and 2: ealth a lem 27 traum		Karen A. Smith 20a. Method of Disposition	20b.	Place of Dispos	ition (Name of c		Date Date	Maryland 20c. Location - City of	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation	C1	crematory or oth Len Have		Pk.	01/22/08	Glen Burn	ie, Maryland
	Baltin permit. P Departme Importar injury or		21. Signature of Funeral Service L	спу:		_			Home, P.A.	
		9. 93	ALT bo	llis	1 32	04 Moun	itain R	oad Pasade	na. Marvla	nd 21122 Approximate Interval
	Physician Medical	95 100	23a. Part I. Enter the disease, or callilure. List only one cause of	n each line.	n. Do not enter ti	ne mode of dying	g, such as car	diac or respiratory ame	est, shock, or neart	Between Onset and Death
7	aminer		Immediate Cause (Final disease or condition resulting in death)	a. Ischemic bowel Due to (or as a consequence of	of):					-
		L	Sequentially list conditions,	b. Hypertensive athe		tic cardi	ovascula	ar di <i>s</i> ease		
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of						-
	isi Ja	Exar	events resulting in death) Last	Due to (or as a consequence of	of):					
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	YUNPENDED	d	. Mr3 -	077 2/12	/00 mm	3b,2/,28a-f p	er ME g878 4/	/8/08 amh
	760, cate be physici he buri	Med	IF FEMALE:	23c. If yes, outcome of pred	gnancy	011 3/12/	<u>w 11 _</u>		23d. Date of deliver	
	certification see as t	Physician/	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of de	ooth -	tal death 3 her (Specify)	Ectopic	pregnancy	Month	Day Year
	Box e death the atte	hysi	1 Yes 2 No 9 Unkn	own g Unknown	00	Tier (Opcomy)				
	that the led by detache	by P	Part II. Other significant condition	ns contributing to death but not	resulting in the u	inderlying cause	e given in Par			to the cause of death?
	ds, F quires en sign uld be	ted								autopsy findings available
	COCC law re has be e 2 sho	Completed	<u> </u>		-				rmed? death	
	l Re n: The tificate or, pag	S	25. Was case referred to medical			26.Pla	ce of Death (1 Yes Check only one)	2 No 1 🗸	Yes 2 No
	Vita tysician this cer direct	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other ₄	Nursing Home 5	Residence 6 🗸 Ott	her: Scene
5	n of ling Pt After funeral	ı.	27. Manner of Death 1 X Natural 5 Pendin	28a. Date of Injury (Month, Day, Year)	28b. Time of	njury 28c. Ir	ijury at Work?		how injury occurred	
	Sior Attend death retor:	catic	- 1 Clidii	igation 28e. Place of Injury - At h	unk	et factory office	Yes 2 X		Street and Number or	Rural Route Number, City
H	Divi	Certification:	3 Suicide 6 X Could 4 Homicide determ	not be	nome, iaim, sire	et, lactory, onlo	- unle	or Town.		, total , total , tanker, any
	Hospi 24 hou Funer rely fil	<u>a</u>	29a. Certifier 1 Certifying Phy	ysician: To the best of my knowled	dge, death occu	rred at the time,	date and place	ce, and due to the caus	se(s) and manner as s	tated.
	Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Medical	one) 2 Medical Exam	niner:On the basis of examination and manner stated.	and/or investiga			urred at the time, date		
		Σ	29b. Signature and title of certifier	_		i i	nse number C.M.E.		January 18, 20	
			30 Name and address of person	MO completed cause of death (Itel	m 23a)	1 0.0	ton:		1	
	-0		Tasha Greenberg MD.	Assistant Medical Exar		Penn Stree	t, Baltimor	e, MD 21201		
		tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	A) -		-		
	Regis	arar	IAN 2 3	4000 A.	as Done	6257				

08-00491 Bria

Please Type or Print in Black Indelible Ink

Ensure All Copies Are I egible

Brian Hart		FIE		e of Maryland								-	0.0	8 0122
		I- For State Registrar			Cer	tificate o	f Deat	h				eg. No.		
Physicia Medical Examir	ег		Frank1:	in Hart							Date of Deat Month January 1	Day Ye 7, 2008		3. Time of Death 1934 hrs
f.		,	f not institution, g uare Hospital	live street and number)			4b. City, [*] Rose		Location of			4c. County Baltimo	re Cou	inty
Funeral Director		5. Social Security N 213.52	/170	Sex 7. Ag ✓ M 2 F	e (In yrs. Ia	ist birthday) Yr	Month	er 1 Year ns Days		24Hrs. Min.	1	th(MM/DD/YYY 7.1957	Foreig	thplace (State or on on on on on on on on on on on on on
b .	ļ	Usual Residence of			Lie	-								10d. Inside City Limits
nd show any	۲	10a. State MD	10b.County Baltin	nore		Town or Loca seda1								1 Yes 2 No
the Maryla a or 28a-f.	Director	10e. Street and Nui 5716 T1		Mill Road			10f. Zip	120	6		1	09. Citizen of W		ntry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed	ed 2 Marrie	12. Was Decedent Armed Forces' 1 Yes 2 ed If Yes, Give Year			Yes, speci	ify Cuban	panic Origir , Mexican, F specify:		cify Yes or No tican, etc.)	Whi Specify:	te, etc. Whi	
hours :				only highest grade cor		16a. Decede			ion (Give ki DO NOT u			16b. Kind of B		Industry
1036 vithin 72 } ene. rr than "r	Completed	Elementary/Seco		College (1-4 or 4	5+)	Acco		nt				Corpo	rat	ion
1215-0 be filed v ental Hygi rrked other	Richard Hart Eleano							anoi	Deal	-				
MD 21 1.2 should th and Mel 1.27 is ma umatic ev	٤									Rosedal	le,	MD 21206		
nore, I ages I and nt of Heal t: If item other tra			Cremation :	Removal from St		Place of Dispo rematory or o					Date . 22.08	20c. Location Belts		Town, State
Baltin Sermit. Pr Departmen Importan Injury or	1	Donation 5 21 Signature of Fu	Other Speci neral Service Lic		0.00									hrmannPA nore, MD
Physician		23a. Part I. Enter the failure. List on	ne disease, or cor ly one cause on	mplications that caused each line.	the death.									Approximate Interval Between Onset and
Medical vaminer		Immediate Cause (or condition resulti	Final disease	a. Hypertensive Due to (or as a cons			otic c	ardic	vascula	ar di	9000			Death
	ē.	Sequentially list co if any, leading to in	nmediate	b. Due to (or as a cons	equence o	f):								
d sit	Examiner	(Disease or injury t	use. Enter Underlying Cause isease or injury that initiated ents resulting in death) Last											
e execute	dical	X UNPENDED		d. X AMENDED 27	perMF	a875 1	/25/08	 זייי						
68760 ertificate biding physice as the bu	ŝ	IF FEMALE: 23b. Was decedent past 12 months	pregnant in the	1 Live birth 4 Pregnant a	ille of preg	2 F	etal death	3	Ectopic	pregnan	псу	23d. Date Month		y Day Year
Box he death of the atten	hysi	1 Yes 2 1		9 Unknown		1,					220 Did t	200000000000000000000000000000000000000	tributo to	the source of death?
S, P.O. irres that the signed by	ρ	Part II. Other signi	ificant condition	s contributing to dea	th but not r	esuiting in the	underlyin	g cause (given in Par	τι.			-	the cause of death? bably 4 V Unknown
#1- 14 main. of Vital Records, P. (ing Physician: The law requires tha After this certificate has been signed uneral director, page 2 should be determined.	Completed		-								24a. Was auto perfo	psy ormed?	prior to death?	utopsy findings available completion of cause of
rtifical		25. Was case refer	red to medical	 				26.Place	of Death (Check o		2 10	1 🗸 Y	es 2 NO
of Vital of Vital fig Physician fler this certi	o Be	examiner?	2 No	Hospital: 1 Inpati	ent 2 🗸	ER/Outpatier	nt 3 🗌	DOA	Other ₄	Nursing	Home 5	Residence 6	Othe	er:
On of or arth.	tion: T	27. Manner of Dear	th 5 Pending		ury Year)	28b. Time of	Injury		ry at Work? Yes 2		28d. Describe	how injury occu	rred	
25. Was case referred to medical examiner? 1							ural Route Number, City							
he Hospid in 24 hours he Funer.		29a. Certifier 1		ician: To the best of n										
Within To the comple	Medical	29b. Signature and		and manner stated					e number					onth, Day, Year)
	_	1 Som	dorke	u()				O.C.				January 1	8, 200)8
		30: Name and add	· · · · · · · · · · · · · · · · · · ·	no completed cause of istant Medical Ex		^{23a)} 111 Pen	n Stree	t, Baltir	more, MI	2120	01			
Sta Regist		31. Date filed (Mon	0 0 000	32. Registr	ar's Signati	ure Angle								

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 RITA Physician HUDLICKA 8.35 EM 01 70 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMOR E. CITY GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Days 1 □ M 2 🖼 F MD Director 213.20.9752 07, 19, 1926 81 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 XYes 2 No N/A Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or U.S.A. 5108 Holder Avenue 21214 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ZWo Specify: White ģ 3 Widowed 4 Divorced Completed r than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Ith and Mental Hygiene.
27 is marked other than " College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other
any Injury or other traumatic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbur Pulkett Mary Matula 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2821 Alvarado Square, Baltimore MD 21234 of Disposition (Name of Date 20c. Location - City or Town, State <u>Cynthia Lanham/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01.22.07 Beltsville, MD Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cafa/Stephen D. LohrmannPA 8717 Green Pastures Dr. BAlto., 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPERKALEMIA **Physician** /Medical Due to (or as a consequence of): Examiner RENAL FAILURE ACUTE Sequentially list conditions, Due to for es a consequence of): if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner URINARY TRACT INFECTION WITH SEPSIS. certificate be executed burial-tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE TO DEMENTIA 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 ☐ Pending investigation ...al or Att.

ours after deatt.

al Director: Att.
in by the fur-1 🗖 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Box 68760, P.O. Division or Vital Records,

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

NADRA NASIR KITAN. 5601, LOCH RAVEN BLVD, BALTIMORE, MD 21239.

khan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

65156

29d. Date signed (Month, Day, Year)

Jan 20, 2008.

08-00512	
Joseph A.	Jefferson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificat Registrar Certificat	te of Death	Reg. No.	0 0166
Physici		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year	3. Time of Death
edical Exami	ner	Joseph A. Jetterson		January 18, 2008	0734 hrs
		4a. Facility Nanle (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Dear	th 1
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birtho		. 8. Date of Birth(MM/DD/YYYY) 9./B	Intholace (State or
Director		215-28-6659 1XM 2 F 72	Yrs. Months Days Hours Min.	Fore	
	1	Usual Residence of Decedent	113.	IAUg.11,11351	Wid.
v any		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
fand fshor	io	Ma. I NIA Bal-	timore		1 Yes 2 No
: Mary r 28a- ed at	irec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	untry?
ith the 23a o notifi	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1	2/2/5	USF	
eath w items ust be	ıner	1 Never Married 2 X Married Armed Forces?	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 		rican Indian, Black,
fier de l", or		1 X Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	Specify: R/	ack
tours a	Completed by		ecedent's Usual Occupation (Give kind of varing most of working life, DO NOT use reti		s/Industry
n 72 h	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	ining most of working life. DO NOT use reti	red)	r.
-000 withing giene.	om	17. Father's Name (First, Middle, Last)	CULITY OFFICE	er Private	2 tism
21215-0036 unld be filed within 7 Mental Hygiene. marked other than c event, the Medica	BeC	Tocach Teffenson	Trans	(First, Middle, Maider Surfame)	-1
213 ould b d Men s mar	2	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or F	Rural Route Number, City or Town, Star	te, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teaths and Montab Filed within 72 hours after death with the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f shu traumatic event, the Medical Examiner must be notified at once		Mrs. Margaret Jefferson 3.	511 W. Garrison	n Ave. Balto, 1	Md. 21215
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "matural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.			Disposition (Name of cemetery, y or other place)	Date 20c. Location - City o	or Town, State
Baltimore, permit. Pages I an Department of Her Important: If ite		4 Donation 5 Other Specify: Garris	son Forest 1/3	0/2008 Dwings 1	Mills, Md.
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of sel and 2 should be filed withi Important: If item 27 is marked other hinjury or other traumatic event, the Med		21 Signature of Funeral Service Licensee	22. Name and Address of Facility Joseph L. Russ Fu	ieral Home, P.A.	
Physician		23a. In I. Ent. The disease, or com the tions the caused the death. Do not one	12222 Wi North AV	e. Bulto. Mai 2	Approximate Interval
		failure. List nly one cause on each line. Immediate Cause (Final disease a. Atherosclerotic Cardiovascula			Between Onset and Death
'xaminer		or condition resulting in death) Due to (or as a consequence of):			
	Ē	Sequentially list conditions, if any, leading to immediate			-
- 1	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C.			1
<u>™</u> † <u>E</u>	Exa	events resulting in death) Last Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. The the law requires that the death certificate be executed for the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	d. UNPENDED AMENDED			-
'60, cate be ohysic	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery
687 certific nding p	sician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death s	Fetal death 3 Ectopic pregna	ancy Month	Day Year
Box 68's death certification attending	ysic	1 Yes 2 No 9 Unknown g Unknown	Other (Specify)		j
of Vital Records, P.O. Box 68 ling Physician: The law requires that the death certificate has been signed by the attending funeral director, page 2 should be detached for use as it.	y Phys	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part f.	23e. Did tobacco use contribute t	o the cause of death?
ires th	d by			1 Yes 2 No 3 Pr	obably 4 Unknown
ords w requisite per should	Completed				autopsy findings available completion of cause of
Reco	mo:			performed? death?	_
tal Filant certifi ector,	Be	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)	
Division of Vital Records, tal or Attending Physician: The law requirers after deart. After this certificate has been sited in by the funeral director, page 2 should be	2	1 ✓ Yes 2 No Pospital 1 Inpatient 2 ✓ ER/Out		ng Home 5 Residence 6 Oth	er:
iding th. : Afte	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Tit	me of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
isio	icat	2 Accident Investigation 280 Place of Injury. At home for	n, street, factory, office building, etc.	28f. Location (Street and Number or F	Rural Route Number City
Divisior pital or Attend ours after death teral Director:	Certification:	Suicide 6 Could not be determined (Specify)	,	or Town, State)	
Divisior To the Hospital or Attend within 24 hours after death To the Funcral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, and	due to the cause(s) and manner as sta	ated.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.		at the time, date and place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	
./		Valyrie The Well	O.C.M.E.	January 19, 200	U Ø
5		Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD	21201	
S	ate				
Regis		MN 2 3 2008 Some	Cooks		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2008 4:24 A.M Vlable James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 16/1946 Min. Months Hours 241-82-5170 NC Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at MI Baltimore 1 Tres 2 No Director 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. the Medical Examiner 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 7 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Cook Nusina permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ <u>xmes</u> Marv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20174 /Sister 10647 Campus Way South Upper Marlburg MD
ce of Disposition (Name of Date 20c. Location - City or Town, State Minnie James Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Wi Sames Cemetery 1/04/000 MICHIER HILL NO.

22. Name and Address of Facility Volume C. Green Funeral Services 1/26/2008 Maple Hill, NC 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 4905 York And Baltimore, MI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 No 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 / Inpatient 2 ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury within 24 hours americant To the Funeral Director: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 iscelle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

ELENA

31. Date filed (Month, Day, Year)

SABAEVA

2008

GSH

32. Registrar's Signature

280/2

5601 LOCH RAVEN BLVD BALTIMORE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 43 **Physician** 2008 HARLES - DWARD, jan 21 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Howard County General Hospital Columbia 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) May 31, 1928 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours **Funeral** Months 1 M 2 □ F 79 220-30-3448 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Ellicott City MD Howard Director 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number USA 21043 3536 Manor Lane Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Specify: Black 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Effie Hammond Joseph L. Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3701 Twin Lake Ct., Baltimore, MD 21244 Mrs. Darlene Jones (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cooksville, MD Bushy Park Cemetery 1/25/2008 PACIFICATION ACCURACY NAME & CHAPEL, PA (Box 195) Sykesville, MD 21784 21. Signature of Funeral Service Licenses Gran 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1004612 Physician disease or condition resulting in death) /Medical Due to (or as a consequence f) **Examiner** Small howe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit (on olon Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □ No 25 1 ☐Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA 1 ☐ Yes 2 ER/Outpatient Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 24 To the F

State Registrar

DASENBROOK 1 MM> ELL10TT 31. Date filed (Month, Day, Year)

30. Name an address person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

MS

10724

29c. License number

00065050

29d. Date signed (Month, Day, Year)

JAN 21, 2008

LITTLE PATURENT PRINT, COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 12:20 PM Janyan Nicolette M. Jessop 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City Baltimore Baltimore Hospital 40 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min Months Days 1 M 2 Tr Director 219-28-9856 24,1930 Maryland Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene. tem 27 is marked other than "naturat", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10 Apple Tree Court 21228 **USA** Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc 1 Never Married 28 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White <u>ک</u> 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Salvatore Maranto Sarah Citrano ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trai Frederick Jessop 10 Apple Tree Court; Catonsville, Maryland 21228 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 DBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation Lake View Mem. Park 1/25/2008 Sykesville, Maryland 5 Other (Specify) 21. Signature of Filtral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catonsville Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stors **Physician** week /Medical Due to (or as a consequence of): Examiner Penfoniti's Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ breast cancer 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown IV metastatic Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 npatient 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f 2 ☐ Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 2008 RES- 500 21 10

Registrar DHMH 17 Rev 1/2001

State

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Sinae

32. Registrar's Signature

Onucha

2008

23

Undi

31. Date filled (Month, Day, Year)

Director

Funeral

Completed by

Be

2

Examiner

Physician/Medical

Be Completed by

P

Certification:

Medical

29b. Signature and title of certifier

Physician

/Medical

Examiner

Funeral Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas peperfment of Health and Mental Hygienia. His interest is a marked other than "natural", or items 23a or 28a-f show Important: If from 27 is marked other than "natural", or items 23a or 28a-f show any injun; or other traumatic event, the Medical Examiner must be notified at

Physician /Medical Examiner

burial-trar

	Please	Type or P								-		egible.		
For State Registrar		State of	Maryland	-			lealth <i>Death</i>		1en		ene g. No. 🤉	nno	2 01	777
Registrar Decedent's Name	e (First, Middle, La	ast)								Date of Death	1) ليانيا (3. Time of	Death
Marv		Δα	sisi		т.	ack	son			Month	Day	2008	1:35	M .
4a. Facility Name (/	f not institution, gi			4b. City, Town, or Location of Death					<u> </u>		unty of Dea			
Stella	Maris	Hospice		Towson				Baltimore						
5. Social Security N	lumber 6.	Sex 7.	Age (In yrs. las	t birthday)	If Unde	r 1 Year	If Unde		8. [Date of Birth (Month, Day,	Year)	9. Bir	thplace (State or	Foreign
220-58-	1760	1□ M 2 X F	84	Yrs.	WOTER	Days	liouio		09		23		MI)
Usual Residence of 10a. State	Decedent 10b. County		10c. City,	Town or Lo	cation								10d. Inside Cit	v Limits
MD	MD			Balt		٠.							1 X Yes	´
				Dare.	_	p Code				10	n Citizei	n of What Co	nuntry?	
10e. Street and Nu	_				101. 21		227			10				
701 Gui	n Road_	12. Was Decede	ant Ever in II S	13 \	Nas Dec		227	rigin? (Sn	ecify	Yes or No-		Bace - Ame	enican Indian,	
11. Marital Status	ied 2□ Married	Armed Force	es?	13.	f Yes, sp	ecify Cub	an, Mexic	an, Puerto	Rica	Yes or No- an, etc.)	' ''	Black, Whit		ĺ
3 ☐ Widowed		1 ☐ Yes 2 If Yes, Give Year or Date	X ⊒		1 ☐ Yes	2 X No	Specify 5 1	y:			S	ecify:	Black	
<i>'</i> C	15. Decedent's E	ducation		16a. Deced	dent's Usi	ual Occup	ation	not of work	inc	1	6b. Kind	of Business	/Industry	
(Spec	ondary (0-12)	rade completed) College (1-4	or 5+)	life. l	KIND OF W DO NOT (use retire	during mo d)	ost of work	ung				_	
12th gra		na	,		Tea	che						Scho	ols	
17. Father's Name		t)								irst, Middle, M	laiden Su	rname)		
Arthur	Jackson						Ros	a St	r	1p				
19a. Informant's N					•					oute Number,				
Sister	Richard	o Maddo					ad,			more,	Md	212		
20a. Method of Dis		□Removal from St	cen	ce of Dispo netery, crei	sition (Na natory or	ame of other pla			Date			•	r Town, State	
	5 Other (Spec		Lou	don :	Park		1	./23/	/08	8 Ba	alti	.more	, Md	
21. Signature of Fo	uneral Service Lice	ee /		22 M	Name a	and Addre	ess of Fac H We	ility						
CH2	Ime 7	H. Ohi	mpen		300	Wab	ash	Ave	_	Balti	nore	, Md	2121.	5
23a. Part 1. Enter to shock, or hea	the disease, or con	nplications that cau	used the death.	Do not ent	er the mo	de of dyi	ng, such a	as cardiac	or re	espiratory arre	st,		Approximate Interval Bety	veen
Immediate Cause disease or condition	(Final	12/02/02/09/03	CANCER										Onset and E	eath
resulting in death)	-		as a conseque									-		
Convention list on	and this are	h =												
Sequentially list co if any, leading to in cause. Enter Under	nmediate	Due to (or	r as a conseque	nce of):										
that initiated events	injury S	C												
resulting in death)	Last	Due to (or	r as a conseque	nce of):										
		d												
IF FEMALE:		_												
23b. Was deceder		23c. if yes, outco	ome pf pregnand th 2 Fetal d		Ectopic	pregnanc	:y				230	d. Date of de Month	,	'ear
in the past 12 1 ☐ Yes 2	K I No	4∐Pregna 9∐Unknov	nt at time of dea		Other (WOITH	Day	eai
9 Unknowr									$\overline{}$	00- Dida-b			1- th- serves of d	
Part II. Other signi	ficant conditions	contributing to dea	th but not result	ing in the u	nderlying	cause giv	ven in Par	T 1.					to the cause of d	
				-						1 L Ye	s 2[]	No 3∏P	robably 4 A L	Inknown
										24a. Was an	,	24b. Were a	utopsy findings a	available ause of
										perform	ned?	death? 1 ☐ Ye		
25. Was case refe examiner?	rred to medical					1		ce of Deat	th (C	heck only one	e)			
1 ☐ Yes 2 X	No	Hospital: 1 In	oatient 2 El	R/Outpatier	nt 3 🗆 🗅	OA Oth	her: 4□I	Nursing Ho	ome	5 ☐ Reside	nce 6	Other (Sp	ecify) HOSP	ICE
27. Manner of Dea 1 X Natural 2 ☐ Accident	th 5 □ Pending investigatio	'	Injury 2 , Day Year)	8b. Time o Injury	f M	28c. Inju Wo 1 🗀	ryat rk?]Yes 2[□No	28d.	. Describe ho	w injury o	occurred		
3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Place of building	f injury - At hom g, etc. (Specify)	ne, farm, str	eet, facto	ory, office			28f.	Location (Str City or Town		Number or F	Rural Route Num	ber,
29a. Certifier (Check only one)	1 Certifying F	Physician: To the base aminer: On the base and manne	sis of examination	led g e, deat on and/or in	h occurre vestigation	ed at the ton, in my	ime, date opinion, d	and place, leath occur	, and	I due to the ca at the time, da	ause(s) a ate and p	nd manner a lace, and du	as stated. ue to the cause(s)

The law requires that the death certificate be executed To the Hospital or Attending Physician. The law requires that the death certificate be exwitin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760,

State

Registrar

DHMH 17 Rev 1/2001

TARIO MAHMOOD 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

32. Registrar's Signature

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

6/08

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - For Amend #17, perFH, PI line b per MD, 8875 titlicate of Death

Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN. 15 2008 11:15A WINSTON HENRY JOHNSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE FOREST HAVEN NURSING HOME CATONSVILLE 9. Birthplace (State or Foreign Country)
NEW JERSEY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/10/1925 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F 219-18-1742 Director 82 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at XXYes 2 ☐ No MD N/A BALTIMORE CITY Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3300 BENSON AVENUE, APT. #330 21227 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? U.S. 1 M/Yes 2 □ No ARMY If Yes, Give Year or Dates: 1944–46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XNever Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ALLIED CHEMICAL CORP. CHEMICAL ENGINEER 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARRIE JOHNSON ပ Leonard Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEIGHTON B. EVANS / SON 1936 FEATHERBED LANE, GWYNN OAK, MD 21207 20b, Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State MARYTAND VETERANS GARRISON FOREST 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CEM 01/28/08 OWINGS MILLS, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility neral Service Licenses 21. Signature of F HOWELL FUNERAL HOME any 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 21207 or complications that caused the death. List only one cause on each line. Approximate Interval Between Onset and Death ter the diseas , or heart failure Do not enter the mode of dying, such as cardiac or respiratory arrest, Cause (Final condition Immediate **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Chronic renal disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical attending p for use as as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached to 1 Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 1□ Yes the Hospital or Attending Physician: Be 25. Was case referred to examiner? 26. Place of Death (Offeck only one, Hospital: Other: 1 ☐ Yes 2 N 3 ☐ DOA Certification: To 1 Inpatient 2 ER/Outpatient 4☐ Nureing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Beath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(0

23

Year)

31. Date filed (Month, Day,

0e

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 20, 2008 1918 hrs Medical Examiner GERALD 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) NIA **Baltimore** Mercy Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Country) Months Davs Hours 0410 Director 1 M Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No or items 23a or 28a-f show CARROL mb Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.
ant: If iten 27 is marked other than "natural", or items 23a or 28a-7 sho 10g. Citizen of What Country? 10e. Street and Numbe notified at 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1972-Married Never Married 1 Yes WHITE If Yes, Give Year 1976 1 Yes 2 No specify: 4 Divorced ģ 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 NDEDENDENT CONTRACTOR 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) KEMP traumatic event, Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Stkesville mo COURT LITTLEWOOD rtment of Health an ortant: If item 27 y or other trauma 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 2 Cremation Removal from State Burial 124/2008 Department o Carroll Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ELDERSBURG KENVILLE RO 6028 It is not the dispass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ailure. List only one of use on each line. Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical UNPENDED AMENDED g physician : the burial -Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 . Ectopic pregnancy Year Day Live birth Fetal death use as 1 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 V Unknown þ Be Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy After this certificate has performed death? Yes 2 V No No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other₄ DOA Nursing Home 5 Residence 6 2 FR/Outpatient 3 Inpatient ٩ 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 22, 2008 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201

Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day Year,

2008

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 01-19-2008 **Physician** 400 P M John G. Klein /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace *(State or Foreign Country)*Maryland 8. Date of Birth (Month, Day, Year) 07-11-1945 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 □ F 220-42-8709 62 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director Maryland Harford Edgewood 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number death with U.S.A. 21040 Funeral 408 Silverside Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4or 5+) Masonry Bricklayer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Bena George Klein ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Silverside Rd Edgewood, MD 21040 Health a Charlotte Klein (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 01-23-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bavview Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastases **Physician** Cuenta Wer /Medical Due to (or as a consequence of): Examiner junter) Cance Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2□ No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 **X** No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NWSCO 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation Injury 1 Natural n 24 hours after death.
The Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) and manner stated. the 29c. License number 5 8 3 0 3 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 3 2

29b. Signature and title of certifier

MON



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State Registrar	te of Maryland / Dep	artment of Health and rtificate of Death	Reg.	ZUUÖ	01231	
	Dhyojoj		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death	
	Physicia /Medic		John Rowland Kraft				20 2008	9:10 P ^M	
	Examin	er	4a. Fecility Name (If not institution, give street a	and number)	4b. City, Town, or Location of De	ath	4c. County of Deeth		
			16133 York Rd. 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	Sparks If Under 1 Year If Under 24 H		Baltimore 9. Birthplace (State or Foreign Country)		
	Funeral Director		214-36-9665 ^{1XM 2}		Months Days Hours Mi	April 30,1	1939 Mary		
	و ي		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	conting		1	10d. Inside City Limits	
	ehov ed et	jo	Maryland Baltimore	Sparks	ocation			1 ☐ Yes 2 📉 No	
	28a-1	rect	10e. Street and Number	Брагкы	10f. Zip Code	10g.	Citizen of What Cour	ntry?	
	3a or	0	16133 York Rd.		21152	1	United Sta	ites	
	death	ner	11. Marital Status 12. Wa	is Decedent Ever in U.S. 13. ned Forces?	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,		
36	itied within 72 hours after death with the Maryland Hygiona ther than "natural", or Items 23a or 28a-f show ant, the Medical Examinar must be notified at	Completed by Funeral Director	1 ☐ Never Married 2XX Married 1 [Yes 2 No	1 ☐ Yes 2 No Specify:		Specity: Wh	nite	
ö	hour tural	ed b	15. Decedent's Education	ar or Dates: 1960–68	dent's Usual Occupation		o. Kind of Business/In		
75	in "ne	plet	(Specify only highest grade comp	oleted) (Give life.	s kind of work done during most of v DO NOT use retired)	vorking			
217	od with	Com	Listination y Color (City)	2 broa	dcast engineer		radio		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)			Name (First, Middle, Maio Birmingham	den Sumame)		
Maryland 21215-0036	d Men narke	ဥ	John Rowland Kraft Sr 19a. Informant's Name/Relationship (Type, Pr		ing Address (Street and Number or		ity or Town State. Zir	o Code)	
Ma	d 2 st th and traur		Jacquelyn Kraft/wife			_	21152	, , , , , , , , , , , , , , , , , , , ,	
ē,	s 1 and 2 of Health a ltem 27 is other trai		20a. Method of Disposition	20b. Place of Disp	osition (Name of imatory or other place)	Date 200	c. Location - City or To	own, State	
E	Page nent o int: If iry or		1 \(\overline{\text{Burial}} \) Burial 2 \(\overline{\text{Cremation}} \) Cremation 3 \(\overline{\text{Percity}} \)	trom State	alley Mem GardJan	. 26,2008 I	Cimonium,	Maryland	
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiens. Important: if item 27 is merked other than "natural; or items 23a or 28a-f show ampoints if it other traumatic event, it a Medical Examinat must be notified at once.		21. Signature of Funeral Service Licensee		2. Name and Address of Facility Mitchell-Wiedefe.		Home, Inc. MD 21212		
	19		23a. Print. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not en	iter the mode of dying, such as card	liac or respiratory arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	HETASTATIC.	LIENG CANE	E/C		LYEARS	
	Examiner			Due to (or as a consequence of):				•	
		Je.		Due to (or as a consequence of).					
	Da Puranti	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<u> </u>					
8760,	death certificate be executed to ettending physicien and dor use as the burial-transit.	al Ex	resulting in death) Last	Due to (or as a consequence of):					
387	physi	dical	d		7.2-11				
Вох 6	eath certific ettending p for use as	n/Me		ves, outcome of pregnancy			23d. Date of deliv		
W	ne death the ette hed for	Physician/Med	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month	Day Year	
P.0	that the do	Phy	9 Unknown		underhing eques given in Part I	23e Did tobao	co use contribute to t	the cause of death?	
	se ug	l by	Part II. Other significant conditions contribut	4	35 TRUCTIVE	1 🗗 Yes		bably 4 Dunknown	
Records,	w requir been s should	Completed	Property 1 Person		TIVE HEART	24a. Was an	24b. Were autr	opsy findings available	
Re	0 4 0	dmo	Fuer de las	ne de men	<	performed	d? prior to co	ompletion of cause of	
tal	ician: Th certificate rector, pag	a	25. Was case referred to medical	16 7/2003/	26. Place of I	1 ☐ Yes 2 P		28.10	
<u> </u>	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospita	tl: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Other: 4 Nursing	g Home 5 A esidenc	e 6 🗀 Other (Speci	ify)	
0 4			27. Manner of Death 28a 1 2 Natural 5 Pending	a. Date of Injury 28b. Time ((Month, Day Year) Injury	Work?	28d. Describe how	injury occurred		
sio	Attending r death. ector; After by the fune	cati	2 Accident investigation	Place of Injury - At home, farm, s	M 1 Yes 2 No	28f Location (Stres	et and Number or Run	ral Route Number.	
Division of Vital	o tte	Certification:	4 Homicide determined 200	building, etc. (Specify)	treet, ractory, ornice	City or Town, S	itate)		
_	To the Hospitel or At within 24 hours after d To the Funerel Direct completely filled in by	edical C	(Check only 2 Medical Examiner: C	. To the best of my knowledge, dealer the basis of examination and/or indicated.	nth occurred at the time, date and planvestigation, in my opinion, death or	ace, and cue to the caus courred at the time, date	le(s) and manner as a and place, and due t	stated to the cause(s)	
	o the o the omple	Med	29b. Signature and title of certifier		29c. License number		. Date signed (Month,		
	P 5 P 0		1/2-1/1/2		05309	5 In	NUMY ZI	1,2008	
	18		30. Name and address of person who complete	ed cause of death (Item 23a) (Type	Print) Tuumoze K	2		<u> </u>	
	1 "			12221 an, 12	Tuismore K	P. limoni	um, july	21093	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 3 2008	32. Registrar's Signature	المثا				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician MAE MALLORY SPENCE KRULAK January 17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5708 Kenmore Road Baltimore 8. Date of Birth (Month, Day, Year) Oct 24, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours Months Min. 1 ☐ M 2 🕅 F 66 1941 Director 260**-**66-3245 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County ıral", or items 23a or 28a-f show I Examiner must be notified at Directo Maryland Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5708 Kenmore Road 21210 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel may hijury or other traumatic event, the Medical Examines ones. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White <u>چ</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Librarian Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Buddig Spence Florence Glass Davis ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. William M. Krulak (Huusband) 5708 Kenmore Road, Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 1/19/2008 Baltimore, Maryland 21. Signature of Fungal Serve Licensee Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Immediate Cause (Final Ghome **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the hirial towns. resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) the red i 9□ Unknown 9 Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 24a. Was an has e 2 e autopsy performed? Yes 2 page 2 certificate 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Peath 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death (nonta 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Certification: 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person cause of death (Item 23a) (Type, Print) 670 IN-Charl ST Tonson un 20204 wo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

2008

USA

Black. White, etc.

10:26 PM

Birthplace (State or Foreign Country)

21210

10d. Inside City Limits

1 X Yes 2 No

Mississippi

DHMH 17 Rev 1/2001

08 Εt

08-00529		Please Type or Print in Black Indelible Ink. Ensure All Copi		gible.	
Ethel Knowles		State of Maryland / Department of Health and Mental H	Hygiene	0.00	0 0100
Dhuaisi	/	1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea	Reg. No.	3. Time of Death
Physicia Medical Exami			Month January 1	Day Year	0220 hrs
,		Ethel C. Knowles 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of Dea	th
3		Franklin Square Hospital Rosedale		Baltimore Co	unty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24H	_	rth(MM/DD/YYYY) 9. B Fore	
Director		220-24-8807 1 M 2xF 78 Yrs. Months Days Hours M	04/1		ountry) MD
Ą.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ow any					1 Yes 2 No
rylanc n-f sh	ctor	MD Baltimore White Marsh 10e. Street and Number 10f. Zip Code	1.	10g. Citizen of What Co	
LLL? vith the Maryland s 23a or 28a-f show is notified at once.)ire				•
uth with the Mar tems 23a or 28.	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No	USA o- 14. Race - Ame	erican Indian, Black,
Jeath ritem	une	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puer Yes 2 X No	to Rican, etc.)	White, etc.	
after	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: Wh	
hours af "natural"		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re-		16b. Kind of Business	/Industry
36 in 72 han " Ilical J	plet	Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker	,	Own Home	
5-0036 iled within 72 Hygiene. Jother than	Completed		ne (First, Middle,	Maiden Surname)	
215 be file stal Hy ked o	Be		a Garts	ide	
ould I Mer Is mar Iic eve	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			te, Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		Millard Byrd Knowles 11704 Larch Road B			-
Baltimore, permit. Pages 1 an Department of Hea Important: If ite njury or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2 - X/	20c. Location - City	or Town, State
lime Page ment tant:		Gardens Of Faren	21-2008	Darormor	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med				k Funeral H	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval
/Medical		failure. List only one cause on each line.			Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			1
**.	L	Sequentially list conditions, b. Bilateral Deen Vein Thrombosis			
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Gause (Cliegere or injury that initiated			
108: =	xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
vecuted wand	cal Examiner	d			
O, e be ex ysician burial		X UNPENDED AMENDED 23a-c, Pt II, 27, 28a-f per ME g877	3/26/08 am		
Box 68760, e death certificate be er the attending physician ed for use as the burial	Physician/Medi	IF FEMALE: 23b. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic preg	nancy	23d. Date of deliver	Day Year
ox 6 ox ox	sicia	past 12 months? 1 Yes 2 No 9 Unknown g Unknown g Unknown			
Be der	hys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did	tobacco use contribute	to the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit		Liver Cirrhosis		31	obably 4 Unknown
ords, w require s been sig	Completed by	Liver cirricosis	24a. Was	s an 24b. Were	autopsy findings available
COF	nple		auto	opsy prior to formed? death	completion of cause of
tal Reco ciau: The law certificate has		25. Was case referred to medical 26.Place of Death (Chec		2 No 1 🗸	Yes 2 No
Vital I ysiciau: his certifi director,	Be	examiner? Hospital: Innation 3 of ED/Outpatient 3 DOA Other; Nur	sing Home 5	Residence 6 Ott	ner:
n of Vi ding Physi After this funeral dir	To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	-	how injury occurred in mo	ton vabiala
lon lendin eath or: A	ation	1 Natural 5 Pending 1/3/08 1:45 pm	collisio		tor verificie
Division of Vital Records, spital or Attending Physiciau: The law requirm hours after death. Ineral Director: After this certificate has been signified in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location	(Street and Number or	Rural Route Number, City
pital Diours a filled filled	Cen	4 Homicide determined (Specify) Street	Allegan	state) ly Ave., Towso	n, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre			
To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (A	
	_	O.C.M.E.		January 19, 20	
		30. Name and address of person who completed cause of death (Item 23a)			
(2)		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201		
Total Park Control of the Control of	ate	1 - 1 O 5 /1110 1		2012	
Regist	rar	JAN 2 2 2000 particular and particul		OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #5, perFH,g875, 1/29/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** LEUNARD WALTER 01 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE REHABILITATION EXTENDED GARE BALTIMORE If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth __(Month, Day, 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Director Usual Residence the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10h. County 1 res 2 No by Funeral Director MD 1 timore 10g. Citizen of What Country? 10f. Zip Code 2121 10e. Street and Number ms 23a or 7 death with "natural", or items Race Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 and 2 should be filed within 72 hours after Yes 2☐ If Yes, Give Year or Dates: 2 No 1 Never Married Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) econdary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maide 17. Father's Name (First, Middle, Last) h and Mental F Be ٥ e.a01a oreh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If item 27 is any injury or other trauonce. 0 10.MI 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Baltinore, MD 21. Signature of Funeral Service Licensee PORK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dring, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LEUKEMIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has autopsy
performed?

1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death, 2 Accident 24 hours after death e Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D30272 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 LOCH RAVEN BOULEV ARD BATIMONE 3900 5. MILLER THOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		rtificate of			ene eg. N67	01235
ľ	Physicia	an	1. Decedent's Name (First, Middle, Las		T 1 1	G		2. Date of Deat Month	Day Year	. 3. Time of Death
	/Medic	al		Harold Ray	Lintz,		- Leasting of Death	January		
	Examin	er	4a. Facility Name (If not institution, give 7934 North Bound	and the second		Dund	r Location of Death alk		4c. County of De	
enž	Funeral	Œ	Social Security Number 6. S	ex 7. Age (In	yrs. last birthday	if Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9.8	irthplace (State or Foreign
	Director		215-52-1665	© M ² □F 58	Yrs.	Months Days	Hours Min.	Jan. 25		ryland
	and ow t		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	Mary I-f sho fied a	tor	Maryland Bal	timore		D.	undalk			1 ☐ Yes 2 🔀 No
	th the	Jirec	10e. Street and Number		*	10f. Zip Code		1	0g. Citizen of What 0	Country?
	ath wi	ral	7934 North Bou				21222		United S	
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2 ☒ No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	
5	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dece	edent's Usual Occup	pation during most of work	ina I	16b. Kind of Busines	s/Industry
V	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of work d)	,.g	G = t-	
2	filed w Hygie ther t		10 Years 17. Father's Name (First, Middle, Last)			Carpenter	18. Mother's Name	(First, Middle, I	Carpent Maiden Surname)	ry
0	ld be ental ked o	To Be	Jack Lintz				Lucil	le Berry	,	
2	shou and M s mar	-	19a. Informant's Name/Relationship (7			-			; City or Town, State	
	and 2 ealth in 27 i		Mrs. Judith E. L							yland 21222
	Pages 1 tment of H tant: if iter jury or oth		20a. Method of Disposition Y∃Burial 2 □ Cremation 3 □ 4 □ Dopation 5 ☑ Other (Specify	y)	Ho/11/ H	7	Gdns. 1/2	2/2008	20c. Location - City o	iver, MD
מ	permit Depar Impor any in		21. Signature of Fineral Service Ligarity	Nons	1/1/	7922 Wi	ise Ave.	Dundalk	Dundalk, , Maryland	Inc. d 21222
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not er	iter the mode of dyi	ng, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Coronary		Disease				
	Examiner			Chronic C	nsequence oi): Obstruct:	ive Pulmo	nary Dise	ase		
E		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a con						
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	Aortic Va		lacement				
ב ב	oe exe	Ē	resulting in death) Last	Due to (or as a co						
00/00	physicate to the the the the the the the the the the	edical		d Sleep Apr	nea					
O. DOX 0	Attending Physician: The law requires that the death certificate be executed recreating and death. recreation: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of d Month	lelivery Day Year
Ļ	s that ned by	by Ph	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did tol	pacco use contribute	to the cause of death?
20.00	en sig	ed b						1 🗆 Ye	es 2□No 3□	Probably 4 X Unknown
ב	The law racate has be page 2 she	Completed						24a. Was a autops perform	y prior to med? death	autopsy findings available o completion of cause of ? es 2 ☐ No
V [2	ician; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat			
5	Physer this eral di	<u>1</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	of 28c. Inju	4 Nursing Ho	me 52 Reside 28d. Describe ho	ence 6 Other (Sp ow injury occurred	pecify)
5	ath. rr: Afte	atior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		ar) Injury		rk?]Yes 2□No			
ב ב	after der Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - building, etc. (S	At home, farm, sipecify)	treet, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director, p	Medical C	29a. Certifier 1X Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exa and manner stated.	amination and/or i	th occurred at the ti nvestigation, in my	ime, date and place, opinion, death occur	and due to the c red at the time, o	ause(s) and manner late and place, and d	as stated. ue to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	0		29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
	^		Sanney	Wille	MI	D 2	7188		January 22	2, 2008
	7		30. Name and address of person who savinder K. Julk				lalk, Mary	land 2	1222	
H	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	-	read)				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar		epartment of Health and Certificate of Death	, ,	eg. Noo. O. O. O.	0:000
1	16	3	Decedent's Name (First, Middle, Last)			2. Date of Dea	m 2000	3. Time of Death
	Physici /Medio			Voel Long		January	19, 2008	7:28pm [™]
	Examir	ier	4a. Facility Name (If not institution, give street		4b. City, Town, or Location of D Sykesvil		4c. County of Deat	
8	Funeral	-	Fairhaven Health Ca 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 I	Hrs. I & Date of Birth	Carro 9. Birt	
	Director		346−20−5819 ¹ X M ² Usual Residence of Decedent	83 Yı	rs. Months Days Hours N	Min. (Month, Day Sept. 7	, 1924 Co	hplace (State or Foreign untry) IL
	faryland show ed at	j.	10a. State 10b. County MD Carrol1	10c. City, Town	Sykesville			10d. Inside City Limits 1 ☐ Yes 2 📉 No
	r 28a-f	Director	10e. Street and Number		10f. Zip Code	1	0g. Citizen of What Co	untry?
	ath wit 23a o ust be	ralD	7200 Third Avenue (21784		USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married	as Decedent Ever in U.S. med Forces? ☐ Yes 2 ☐ No Yes, Give ar or Dates: WWII	 Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, P 1 □ Yes 2∑ No Specify: 	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
15-0	n 72 h "natu edical	Completed	15. Decedent's Education (Specify only highest grade com	pleted) 16a. [Decedent's Usual Occupation Give kind of work done during most of life. DO NOT use retired)	working	16b. Kind of Business/	Industry
212	y within jiene.	ошо	Elementary/Secondary (0-12)	Dilege (1-4or 5+)	usiness Owner		Hobby Bus	iness
	be filed tal Hygid d other event, th	Be C	17. Father's Name (First, Middle, Last)	_		Name (First, Middle,		
Maryland	2 should be filed vand Mental Hygie is marked other i raumatic event, th	2	Elmer E. Lor				oel	7:- Coda)
Mai	nd 2 st lith and 27 is r r traur		19a. Informant's Name/Relationship (Type. Pr. Mrs. Elizabeth L. Boa	· ·	Mailing Address (Street and Number o 108 Weedom Street		ksburg, VA	
ore,	permit. Pages 1 and 2 Department of Health Important; If Item 27 i any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove	20b. Place of E cemetery,	Disposition (Name of crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore,	tment of lant; if ite		4 ☐ Donation 5 ☐ Other (Specify)	Spring	field Cemetery 1/		Sykesville	<u> </u>
Bal	permit. Departm Importar any inju		21. Signature of Funeral Service Licensee	uget Moores	22 Name and Address of Facility HAIGHT FUNERAL H Sykesville, MD 2	OME & CHAF 1784	PEL, PA (Bo	x 195)
1	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	is the caused the death. Do no see on each line.		diac or respiratory arr	est,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consequence of シャロハ にょ	tay discare			
7.7	.E	ner	Some efforth, Bet over 06 one	Due to (or as a consequence of): -	*		
7	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	tructive long d	iscarc		
68760,	e be e: sician e buria		d		,			
68	rtificat ng phy as the	ledical						7.
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	yes, outcome pf pregnancy □Live birth 2 □ Fetal death □ Pregnant at time of death □Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ds, P.	luires that signed to id be deta	ρ	Part II. Other significant conditions contribut	ing to death but not resulting in t	he underlying cause given in Part I.	23e. Did to	bacco use contribute to es 2 □ No 3 □ Pr	o the cause of death? robably 4 Unknown
or Vital Records,	e law require has been sit je 2 should b	Completed				24a. Was a	n 24b. Were au	utopsy findings available completion of cause of
E E		Com				perfor 1□ Yes	med2 death?	2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	al:	Lout	Death (Check only or		
		7: To	27. Manner of Death 28	a. Date of Injury 28b. Til	me of 28c. Injury at		ence 6 Other (Spe	cify)
ion	Attending F r death. ector: After by the funer	atio	1 Natural 5 ☐ Pending investigation	(Month, Day Year) Inj	ury Work? M 1 ☐ Yes 2 ☐ No			
Division	I or Attendi after death. Director; A I in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of injury - At home, farn building, etc. (Specify)	n, street, factory, office	28f. Location (S City or Tow	treet and Number or Ru n, State)	ural Route Number,
	To the Hospital or within 24 hours affer To the Funeral Director completely filled in I	Medical Co	(Check only 2 Medical Examiner: C		death occurred at the time, date and p			
	To the	Z	29b. Signature and title of certifier	D	29c. License number	2	9d. Date signed (Mont	h, Day, Year)
	4		· Cours Su	Y .	Doosdost		1/23/8	
	10		30. Name and address of person who complete Ana Sarante M.D., 164	ed cause of death (Item 23a) (T 45 Liberty Rd.,	ype, Print) Eldersburg, MD 2	1784		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3 2008	32. Gegistrar's Signature	Cook			
			MINIS	the state of the s	A .			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year LAND 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore <u>St. Agnes Hospital</u> N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea JAN 21, 1 Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🛛 F Hours 245-14-2971 89 1918 Director North Carolina Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show streal Examiner must be notified at 1 ☐ Yes 2 No Director MD **Baltimore** Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane, RTG #328 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural"; or Iten any injury or other traumatic event, the Me Meal Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education **Teacher** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doc Fred Adams Ada Jane Capps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. Bruce Land, III, son 9426 Northgate Road Laurel, Maryland 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 01/21/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Soog 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) durane Teric **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ျှ 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the date and place and place and place and place, and due to the cause(s) and we to the cause(s) and manner as stated. Medical and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 alder 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** January 3008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Flospita 6. Sex If Under 24 Hrs. 8. D 9. Birthplace (State or Foreign Country) Naryland If Under 1 Year 8. Date of Birth (Month, Day, APIIA 7. Age (In yrs. last birthday, **Funeral** Year) Days Min. Months 1 ☐ M 2 🕦 F a Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 2/216 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗖 No Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) oom 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type. Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112H Ba 21229 EVECETI Date 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State 2. Name and Address of Facility OSEPH L, RUSS 21. Signature of Funeral Service Licensee 21216 23a. Parti / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Seissis days /Medical Due to (or as a consequence of): **Examiner** infection Winan Sequentially list conditions, if any man is 1. Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed ecubitus Due to (or as a consequence of) Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has k completely filled in by the funeral director, page 2 s autopsy performed 2□ No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral Director

Be Completed by

ဂ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

and attending physician use for has

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. this After

Division or Vital Records, P.O. Box 68760,

Physician/Medical

completely filled in by the funeral director, after death within 24 hours a To the Funeral L Sa

þ Be Completed Certification: To

3 ☐ Suicide

29a. Certifier

4 Homicide

0

State Registrar 29b. Signature and title of certifier

6 ☐ Could not be

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2008

January

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Memorial

M.D Jagadeesha Union 2. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day,

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jerry W. McGlothan 01-17-2008 1133 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1₩ 2□F Months Hours Min Director 459-82-0725 59 09-18-1948 Texas Usual Residence of Decedent 10a State 10c, City, Town or Location 10d. Inside City Limits r 28a-f show notified at show 1 ☐Yes 27 No Directo Maryland| Queen Annes Chester the 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? if of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be a 4E Oueen Victoria Way 21619 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1. Yes 2 No IfXes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operations Manager Steel Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John E. McGlothan, Jr. Corrine Knipper ೭ Department of Health and M Important: If Item 27 is marl any injury or other traumatl once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Anna McGlothan 4E Queen Victoria Way Chester, MD 21619 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State $01-19-2008 \mid Baltimore$, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Diane Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** UNODE Few hours /Medical Due to (or as a consequence of) interction possible Examiner Few hours yocardia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed physician and s the burial-transi P.O. Box 68760,7 Due to (or as a consequence of) Physician/Medical attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 4 Unknown 2□ No 3 Probably 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 FR/Outpatient 3□ DOA e Hospital or Attending Phy 24 hours after death.

e Funeral Director: After this letely filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2. 29b. Signature and title of certifi 29c. License numbe 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Danie! 31. Date filed (Month, Day, Year)

32. Registrar's Signature Konic

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive 115

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 19,2008 SUSAN RUTH McGUIRE January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Keswick Baltimore None If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** September 8,1916 Months Days 1 □ M Maryland Director 215-18-9252 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 XX es 2 No Director Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 West 40th Street 21211 USA Items 23a must k Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ADNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ner 72 hours after 1 Never Married 2 Married "natural", or It edical Examin Baltimore, Maryland 21215-0036 1 □ Yes XX No White Specify Widowed 4 □ Divorced er than "natura , the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary City of Baltimore is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked othany Injury or other traumatic event Be Franklin Hope McConnell Lura Jane Wills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie L Rich Niece 902 West Northern Parkway Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Angel Hill Cemetery 1/23/08 Havre de Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final **Physician** exis disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate oduce. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) certificate be executed the burial-transit Exami that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy jo in the past 12 menths? 1 ☐ Yes 2 ☐ No 5 Other (specify) detached the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Division 5 Pending investigation 1 □ Yes 2 □ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

6 Sinc 32. Registrar's Signature 31. Date filed /Month

29b. Signature and title of certifier

6701

Completed cause of death (Item 23a) (Type, Print). Charles St. Balto. M. 2,29

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

29c. License number

O.RIGINAL

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G876 2/04/08 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** P^{M} Nellie Margaret Mabry 3:47 2008 14 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) System 12 Namber 5 **Funeral** Hours Months Days 86 5, 1920 Mar. Virginia Director 213 96 0390 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 √Yes 2 No Director MD Prince George's College Park 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4907 Hollywood Road 20740 USA Funeral 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ,0 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced "natural", Completed Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natun any injury or other traumatic event, the Medical once." 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waitress 12th Ø Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Fizer Pauline Burton မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Manley/Daughter 4907 Hollywood Road, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crem. 1/19/2008 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee CLM01103 313 Talbott Avenue, Laurel, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Ca (Final disease or condition resulting in death) **Physician** Sepsis & Urinary tract Infection /Medical Due to (or as a consequence of): Examiner Coumadin Toxicity Sequentially list conditions Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed <u>Hematuria</u> Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□ Yes 2√ No 1 Yes 2 √ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours are death

To the Funeral Director:
completely filled by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

State

1/20/08 7/1Kan

7300 Van Dusen Road, Laurel, MD

20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

S. Kanumuru

31. Date filed (Month, Day, Year) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day - 17 - 08 **Physician** Helen Marie Yingling McElroy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 3 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 ₩ F 219-46-3198 Director 1946 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at MD 1 No 2 No Carroll Sykesville Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 7419 Spout Hill Road 21784 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. white 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) nursing LPN in and 2 should be filed with Health and Mental Hygier tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Cover Yingling Esther Marie Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health an Important: If item 27 is many injury or other Aletha McElroy (daughter) 96 Grand Dr., Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation | 1-21-08 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Dauge Haight Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. SEPTIC SHOCK Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): BACTEREMIA GRAM- NEGATIVE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence offi Examiner PANCYTOPENIA attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, APLASTIC ANEMIA Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 5 Other (specify) signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 🗌 Yes **2X** No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To after death.

I Director: After this of in by the funeral d 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in

10

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Francis Khoo M.D.,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Con the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

30263

29d. Date signed (Month, Day, Year)

1-17-08

1. Decedent's Name (First, Middle, Last)

Mary D. Mikos

Stella Maris

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Director 028-07-9415 90 May 28, 1917 Massachusetts Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8911 Reisterstown Road 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Albert Duda Anna Wzorek ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph W. Mikos, Jr. Son 309 Cigar Loop; Harve de Grace, Maryland 21078 Health Baltimore, if item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages Department of Important: If it any injury or c 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 1/24/2008 Elkridge, Maryland 21. Signature of Faneral Service Idensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1401290 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he of failure. List only one cause on earling. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical exteriose fros Due to (or se a consequence of): **Examiner** Sequentially list conditions Due to Lorins a porteocularios offi Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bunial-tran Due to (or as a consequence of): attending physician for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ∐ Yes 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Under the time, date and place, and due to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature a of gertifier D 15504 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 DR. EDDIE NAKHUDA 2300 DULANEY VALLEY RD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

Timonium

2. Date of Death

January

19,

2008

Baltimore

4c. County of Death

7:15 A.M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Carolyn Copeland Marshall Month 17, 12:15 p^M January 2008 /Medical 4a. Facility Name (If not institution, give street and number)
Potomac Valley Nursing Home 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Oay, Year 7/16/1926) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 81 577-38-3511 1 ☐ M 2 🖼 F Illinois Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits •how Item 27 is marked other then "natural", or itema 23a or 28a-1 ebor other traumatic event, the Madical Examiliar must be notified at 1 ☐ Yes 2 No MD Montgomery Rockville Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 1235 Potomac Valley Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. and 11 fem 27 is marked other then "natural", or itel ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Administrative Assistant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Seba Marshall Helen Dorcus Magee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10088 Poplar Hall Ct.; Mechanics ville, VA 23116 Item 27 John Dietrich/personal rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ö 1 ☐ Burial 2 KCremation 3 ☐ Removal from State Department of Important: If eny Injury or one one 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/22/2008 Beltsville, MO 933 Gist Ave. 20910 22. Name and Address of Facility Rapp Funeral & Cremation Svc.; Silver Spring, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** aemorma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 25(No 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital Medical 29a. Certifier to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Research BLVD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2

rata 2401
32. Angistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month Physician Donald Macleod 6:30 A M January 20. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Oak Crest Village Care Center Parkville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 31 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F 1914 93 Canada Director 156-28-7174 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director MD Parkville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 8830 Walther Boulevard 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clergyman/Professor Religion/Education 5+ Health and Mental Hygi tem 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MacKenzie Donald Macleod Anne ဥ other traumatic 19th Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
OIGTIELDS School For Girls
1500 G, Glencoe Road, Glencoe, MD 21152 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
important: If item 27 is
any injury or other trau
once. Anne Macleod Weeks - Daughter Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 1/20/2008 Baltimore, MD 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Cremation Society of Maryland, Inc. න<u>ු</u> Williams 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SCVD disease or condition resulting in death) A /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of it just) that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9□Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown lardementic 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe this certificate 1□ Yes 2☑ No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 864 January 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parksillo MD 21234 Bou levas Monias

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 23

2008

630

00

0

ONAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MATSON 08 ty mond 22 /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkville Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** Year) Months Days Hours 1**火**□M 2□F 180-22-2735 6/1/1928 Pennsylvania 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show e notified at 1 ☐Yes 2 No MD Baltimore Parkville Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ral", or items 23a or Examiner must be r 21234 USA apt # 3601 8810 Walther Blvd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2/XNo if Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Year or Dates: "natural", Completed than "natur the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B.G.E Quality Control Supervisor +4 Department of Health and Mental Hygi Important: If Item 27 Is marked other any injury or other traumatic event, Ill once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Perla M. Shenberger William E. Matson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 19a. Informant's Name/Relationship (Type. Print) Parkville, MD 8810 <u>Walther Blvd.</u> apt # 3601 Delores H. Matson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1/23/2008 Hilltop_Serv. Corp. |Towson, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): attending physician for use as the burial Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Matson, Raymond 1/22/08 in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown au 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 🗔 No certificate 1□ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3∏ Suicide 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

DHMH 17 Rev 1/2001

State Registrar 6800

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2/2

32. Registrar's Signature

Lupicy

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryand 1 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 20 20 2008 Lillie M. Nelson 6:45 A™ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 18, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday Months Min. 1 □ M 2 🗓 F Davs Hours 250-38-1074 SC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits **Baltimore** 1 √Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5902 Glenkirk Road 21239 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status African American 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) domestic homes 18. Mother's Name (First, Middle, Maiden Surname)
Bessie McKnight 17. Father's Name (First, Middle, Last)

Director Funeral To Be Completed by

10a, State

MD

Physician

/Medical

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore. Maryland 21215-0036

27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Mental Hygiene. arked other than

Health tem 27 | or other

Physician /Medical Examiner

sician and burial-transit I or Attending Physician: The law requires that the death certificate be executed after death. for use as been signed by the should be detached page 2 s has

Division or Vital Records, P.O. Box 68760,

ĭĔ.	EULIE MILLER							
	19a. Informant's Name/Relationship (Type. Print) Mary Norton		19b. Mailing Addres 5902 Glenki	*				Zip Code)
	20a. Method of Disposition	20b. Pla	ce of Disposition (Na	me of	Date	€ 20c.	Location - City o	r Town, State
	12 Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	n State I	netery, crematory or Churches Cem		01/26/2	008 st.	Stephens,	South Carolina
	21. Signature of Funeral Service Licensee			nd Address of Facil berty Road;	wyı			Saltimore Co.
2	Part1. Enter the Milease, or complications that shock, or heaft failure. List only one cause or Immediat ause (Final disease or condition	t caused the death.	Do not enter the mo		s cardiac or re	The state of the s	21133	Approximate Interval Between Onset and Death
	resulting in death)	o (or as a conseque		121-111				
niner	Cause (Disease or injury	o (or as a conseque	nce of):					
dical Exar	that initiated events	o (or as a conseque	nce of):					
Completed by Physician/Medical Examiner	in the past 12 months?	outcome pf pregnance birth 2 Fetal of gnant at time of dea unown	leath 3 □Ectopic p				23d. Date of de Month	elivery Day Year
d by Ph	Part II. Other significant conditions contributing to	death but not result	ing in the underlying (cause given in Part	1.	23e. Did tobacc		to the cause of death? Probably 4 □Unknown
Complete						24a. Was an autopsy performed′	prior to	autopsy findings available completion of cause of s 2 No
Be (25. Was case referred to medical examiner?			26. Plac	e of Death (C	Check only one)		
	Hospital]Inpatient 2 ☐ EI	R/Outpatient 3 D	OA Other: 4N	ursina Home	5 Residence	6 □Other (Sp.	ecify)
ation: 1	27. Manner of Death 1 XVatural 5 ☐ Pending 2 ☐ Accident investigation	e of Injury 2 onth, Day Year)	8b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐	280	I. Describe how in		
Sertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined bui	ce of injury - At hom ding, etc. (Specify)	e, farm, street, factor	y, office	28f.	Location (Street City or Town, St		Rural Route Number,
edical Certification: To	29a. Certifier 1 Certifying Physician: To t (Check only one) 2 Medical Examiner: On the and me	he best of my knowl basis of examination	edge, death occurred on and/or investigation	at the time, date a	ath occurred	due to the cause at the time, date	e(s) and manner a and place, and du	as stated. ue to the cause(s)

within 24 hours after death To the Funeral Director:

filled in by

Medical

State Registrar

29b. Signature and title of certifie

30. Name and address of person with

CARL SPERLING

31. Date filed (Month, Day, Year)

BLVD

completed cause of death (Item 23a) (Type, Print) LOCH

32. Registrar's Signature

RAVEN

5601

29c. License number

D2828

BALTO

MA

29d. Date signed (Month, Day, Year) 1/22/2008

21239

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month Year **Physician** John Riggs Orrick 06:15 a M January 18,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 215-14-3210 84 June 1 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No r 28a-f sh notified Directo Maryland | Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or: any Injury or other traumatic event, the Medical Examiner must be n 21204 United States 1055 W. Joppa Rd., Apt. 725 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: white If Yes, Give Year or Dates: WW II 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) architect architecture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank C. Orrick Mattie Riggs ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Ann Orrick/wife 1055 W. Joppa Rd., Apt. 725 Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Jan. 19,2008 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, 6500 York Rd. Baltimore, Ba. Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e logenous montz /Medical Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician the the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year Day ted by the by

Physician Examiner

Orciell, John Baltimore, Maryland 21215-0036

Completed Be Certification: To ours after death.

Division or Vital Records, P.O. Box 68760,

1 Yes 2 No	4∐Pregnant at time of o 9∐Unknown	death 5 ☐ Other ((specify)			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rhenatoria Arthorias					23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
Pulmonany F	inand			24a. Was an autopsy performed?		
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 ☐ I	Other:	ath (Check only one)	6 □Other (Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	the state of the s	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inj	jury occurred	
3 Suicide 6 Could not 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	hysician: To the best of my kno miner: On the basis of examina and manner stated.				(s) and manner as stated. and place, and due to the cause(s)	

47173

N. Charles

29d. Date signed (Month, Day, Year)

Baltomuse

7008

アノブノブ

within 24 hours a

To the Funeral I

completely filled

Medical

State

Registrar

William 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Lonnell 6301 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 1350 Ethel Lorraine Phillips 01-16-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Hospital Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-17-1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 K 79 Maryland Director 214-26-9532 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 U.S.A. 112 Kensington Pkwy Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 🂢 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Rep. Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah W. Evans Bernard Patrick Kernan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2302 Victorian View Court Fallston, MD 21047 Scott H. Phillips (Son) permit. Pages 1 an Department of Heal Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 01-21-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Loer See 22. Name and Address of Facility Schimunek Funeral Home of Bel Air Inc. 610 W. MacPhail Rd Bel Air, MD 21014 ٥ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eizure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Coronary Due to (or as a consequence of): Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown tolerance 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No or Attending Physiclan; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 2 ō 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No irector: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

State

aura l'inentel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

500 U

32 Registrar's Signature

>

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 3:15P M FRANCES REBECCA COLEMAN PHIPPS January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BLAKEHURST HEALTHCARE CENTER Towson Baltimore County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F Yrs. 8. North Carolina Director 212-07-7589 Oct 1908 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City. Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Directo Marvland | Baltimore County Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21204 1055 West Joppa Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Secretary Medical School 4 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Ira Coleman, M.D. Sallie Frances Harris မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Harry F. Reid, Jr. (Pers.Red.) 1055 West Joppa Road, #552, Towson, Maryland 21204 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery Jan 25,2008 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signance of Eugeral S. Type Lacrisee

Martin D. Lawson 22 Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Jebilita disease or condition resulting in death) /Medical Due to (or as a consequance of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner W gua that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetic re 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ∐ Yes Ž⊠ No 3□ DOA ပု this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Director: within 24 hours af

To the Funeral D

completely filled i

2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location City or T	(Street and Number or Rural Route Number own, State)
		ician: To the best of my knowledge, death occu ler: On the basis of examination and/or investig and manner stated.			
29b. Signature and to	tle of certifier	-ws	29c. License number D 58 30 3	<u> </u>	29d. Date signed (Month, Day, Year) Janvory 22 20
30. Name and address		mpleted cause of death (Item 23a) (Type, Print)	ancey or Ton	SON 1	40sis an
31. Date filed (Month	, Day, Year) 2 3 2008	32. Registrar's Signature	,		

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 18,2008 6:25FM Valerie J. Pence JANUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 07/30/1955 Days Hours Min. 1 □ M 2 💢 F Maryland 219-66-7415 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Cockeysville Director Baltimore filed within 72 hours after death with the l Hygiene. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or ? must be n U.S.A. 21030 10 D. Stirrup Court Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify: White Specify Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Analysis Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 2 should be fin and Mental H Be Jane Sobatka Daniel Groncki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If Item 27 is I any injury or other trausonce. 10308 B Gelding Drive, Cockeysville, MD 21030 Christopher R. Pence, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Gardens of Faith 01/22/08 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. Olejandia J. Blai 5305 Harford Rd., Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CIRRHOSIS OF THE LIVER /Medical Due to (or as a consequence of): Examiner VIRAL HEPATITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 📶 No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ ACUTE RENAL FAILURE 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 2**X**No 1 ☐ Yes 1 2 No funeral director, 25. Was case referred to medica examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? Hospital or Attending Pl 24 hours after death. Funeral Director: After the (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1-18-08 D30263

20

State Registrar

DHMH 17 Rev 1/2001

JAN 2 c.F ZUUĞ

31. Date filed (Month, Day, Year)

7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHOO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMIND THMR, perff, C875, 1/29/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARKER Year **Physician** oneary 4 NORA 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3901 Suitland Road, Apt. #402Prince George's Suitland 8. Date of Birth (Month, Day, June 27 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Ye1/945 1 □ M 2 💢 F Months Hours Days 62 578-60-7043 Mississippi Director Usual Residence of Decedent 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Y□Yes 2□No Director MD Prince George's Suitland Pages 1 and 2 should be filed within 72 hours after death with the nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ıral", or items 23a or Examiner must be r 3901 Suitland Road, Apt. #402 20746 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2x No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced Completed item 27 is marked other than "natu other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrator D.C. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Henry Powell Velma Lee Carney 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melvin Parker, Jr. - Son 3901 Suitland Rd., #402, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crem. Jan, 28, 2008 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 21. Signature of Funeral Service Licenses 2504 28th Street, N.E., Washington, D.C. 20018 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a Part1. Enter the disease, or shock, or heart failure. List only Immediate Cause (Final ment 4 ears Physician disease or condition resulting in death) /Medical Examiner Se usertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be execute use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No
9 □ Unknown 23d Date of delivery 3 ☐ Ectopic pregnancy Day for Month Year 5 Other (specify) been signed by the should be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy 2 No this certificate 1 ☐ Yes 1∐ Yes 2 17 No or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 🔲 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 6 Other (Specify) HUME 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Martner of Death 28c. Injury at Work? After (Month, Day Year) Injury 1 Natural s after dec. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified Name and address of person who completed cause of death (Item 23a) (Type, Print) TENTA in 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 3 2 Registrar

Physician

/Medical

Examiner

١.	Funeral		5. Social Security I	Number	6. Sex 1 □ M 2 X F	7. Age (In yrs. I		Months [Days Hours	Min.	(Month, D.	ay, Year)	C	inplace (State or Foreigi Suntry)	a
16	Director		217-34-	-8010	I IVI ZAJE	6	8 Yrs.			1	<u>2-18</u>	-1939	Mar	yland	_
	P.		Usual Residence of	1		10- 04	. Town as I							10d. Inside City Limits	_
	rylar how lat		10a. State	10b. County		TOC. City	, Town or L	ocation							
	a-f s iffied	cto	MD	Balt	imore Co	о. В	alti	more						1 □Yes 2 No	_
	or 28	ire	10e. Street and Nu	umber				10f. Zip C	ode			10g. Citize	en of What Co	ountry?	
	h wit 23a c st be	Funeral Director	7108 Ea	astbro	ok Aveni	ıe 💮		2	21224				USA		
	deat ms	ner	11. Marital Status		12. Was Dec	cedent Ever in U.	S. 13	. Was Deceder	nt of Hispanic C Cuban, Mexic	rigin? (Speci	fy Yes or N	0- 1-	14. Race - American Indian, Black, White, etc.		
ထ	after or ite	F	1 ☐ Never Mar	ried 2K Mar		2 🔀 No		1 ☐ Yes 2 ፟			ouri, 010.)		0		
03	ral", c	by	3 ☐ Widowed	4 ☐ Divorced	Year or I	Dates:		10 165 24	g No Opecii	у.			Specify: Wh	nite	
5-0	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	ted	(Spe	15. Deceder	nt's Education est grade completed)	16a. Dec	edent's Usual (Decupation	nst of working		16b. Kin	d of Business gentha	/Industry	
21	within iene. than "I	aple.	Elementary/Sec			(1-4or 5+)	life.	DO NOT use	done during mo retired)	g			ationa		
21215-0036	d wil	Completed	12			/ A		Secre						11.5.	_
b	al Hygid I other vent, th	Be (17. Father's Name		•				1	her's Name (i					
<u> a</u>	uld b Vent Irked Itic e	2	Walter	Kaszu	ba				Ste	phani	e Fig	ginsk	(i		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's N	Name/Relations	ship (Type. Print)		19b. Mai	ling Address (S	Street and Num	ber or Rural I	Route Num	ber, City or	Town, State,	Zip Code)	
	1 and 2 Health em 27 i		John Po	yer I	II - Hus	sband	710	8 East	brook	Aven	ue Ba	altin	nore,N	1D 21224 _	
re	es 1 and of He fittern		20a. Method of Dis				lace of Disp	oosition (Name ematory or oth	of er place)	Dat	e	20c. Loc	ation - City or	Town, State	
E	Pages nent of I int: If its iry or o			Cremation 5 ☐ Other (5	3 □Removal fron Specify)	n State	-	-	· · · · · · · · · · · · · · · · · · ·	Jan 22	2.2008	 Ralt	imore.	Maryland	
Baltimore,	artm ortal		21. Signature of F			Dato.		22. Name and	Address of Fac	ility Kacz	orows	ki Fu	neral	Home, P.A.	_
ñ	permit. Page Department of Important: If any Injury of once.			1. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral 1201 Dundalk Avenue Baltimore											
	E MARIE		23a. Part1. Enter	the disease, o	r complications that	caused the death	n. Do not e							Approximate Interval Between	_
	Discolates		Immediate Cause	(Final	t only one cause on		4 11	A						Onset and Death	
	Physician /Medical		disease or conditi- resulting in death)	on)		Cecs 1		BNC	ev					-	_
	Examiner				Due to	(or as a consequ	uence or).								
		70	Sequentially list of	onditions,	b	o (or as a consequ	uence of):								-
	ted 1sit	ni ni	Sequentially list conditions, if any, leading to immediate cause. Lines throughly Cause (Disease or injury												
_	xecur and Il-trar	Examiner	that initiated event resulting in death)	เร	c	o (or as a consequ	uence of):								-
09	be e. ician buria	a E				,	,								
68760,	eath certificate be executed attending physician and for use as the burial-transit	Physician/Medical			d										_
×	ding se as	/Me	IF FEMALE:		23c. If yes. o	utcome pf pregna	ıncv						3d. Date of de	alivon	
Вох	atten for us	ian	23b. Was decede in the past 1:	2 months?	1 ☐ Live	birth 2 Feta	I death 3	☐Ectopic preg					Month	Day Year	
Ö	the de	ysic	1 ☐ Yes 2 9 ☐ Unknow		9□Unk		caiii c	Other topec	y/						
۵.	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	P			ions contributing to	death but not resu	ulting in the	underlying cau	se given in Par	t I.	23e. Did	tobacco us	se contribute	to the cause of death?	
Vital Records,	ires t signe	by			0		ŭ	, ,			1 1	Yes 2]No 3□F	Probably 4 Unknow	n
0	w requir been si should	eted												<u> </u>	
ec	The law I ate has be page 2 sh	pd.									24a. Wa aut	opsy	24b. Were a	utopsy findings available completion of cause of	е
=	The cate h	Compl									per 1∐ Yes	formed? 2 X No	death? 1 ☐ Ye	s 2 No	
Ħ	ctor,	Be (25. Was case refe examiner?	erred to medica						ce of Death (Check only	one)			_
or V	nysic li dire	2	1 ☐ Yes 2K	No No	Hospital: 1	Inpatient 2	ER/Outpati	ent 3□ DOA	Other: 4 🗆 I	Nursing Home	e 5 ⊠ Res	sidence 6	□Other (Sp	ecify)	
0	Attending Physician: The lay rdeath. ector: After this certificate has by the funeral director, page 2		27. Manner of Dea 1 ☑ Natural	ath 5 ∐ Pendi	/8.8-	e of Injury onth, Day Year)	28b. Time Injury	of 286	c. Injury at Work?		d. Describe	e how injury	occurred		
.0	endinath.	atic	2 Accident	invest	igation			М	1 ☐ Yes 2[□No					
Division	er death rector: by the	tific	3 ☐ Suicide 4 ☐ Homicide	6 □ Could deterr	nined 200. Place	ce of injury - At ho ding, etc. (Specif		street, factory,	office	28		(Street and own, State)	l Number or f	Rural Route Number,	
	tal or safter sa al Dire	Certification:													_
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the I		29a. Certifier (Check only		ng Physician: To the I Examiner: On the										
	the H in 24 the F	Medical	one)	1 1		nner stated.									_
	With Volume	Σ	29b. Signature an	title of certific				29c.	License numbe	r	_	29d. Date	e signed (Mor	nth, Day, Year)	
	1			1// //	/// -			$\mathbb{T} \setminus \mathcal{V}$	005	574	2	Janı	uary 1	9, 2008	
1	0 4		30. Name and add	dress persor	who completed ca	use of death (Heat	23a) (Typ	e, Print)							
1	U		Richar	d ["] Ze1				rth Br	oadwa	y Ba	1timo	ore,	MD 21	231	
	Sta		31. Date filed (Mo	onth, Day, Year	3 2000 32.	Registrar's Signa		Acosto)	•			ŕ			
	Regist	ar		JAN 6	U 4000	Destant of	and the	A CONTRACTOR OF THE PARTY OF TH							

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** NATHANIEL RYALS /Medical 4c. County of Death 4b, City, Town, or Location of Death Macility Name (If not institution, give street and number) Examiner Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number Sex XXM 2□F (In yrs. last birthday) **Funeral** Months Days Hours NORTH CAROLINA 245 40 8233 76 MAY 08, 1931 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at XXYes 2□No Director MD BALTIMORE 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 5 23a 21229 UNITED STATES 22 SOUTH ATHOL AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXXNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. X1X Never Married 2 Married 0 1 ☐ Yes ŽXNo Specify: BLACK þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 6TH CONSTRUCTION WORKER PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ JOHN DAVID RYALS LULA B. BAYLOCK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6800 TREXLER ROAD LANHAM, MD 20706 BARBARA M. HOLIDAY / SISTER Injury or other permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other Once. 20a. Method of Disposition
1 ☐ Burial XXCremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 1/12/2008 ALEXANDRIA, VA 21. Signature of Funeral Service Licensee FUNERAL HOME OF MARYLAND, INC. D. STA 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Part 2 ter the disease, or complications that caused the death. Do not enter the shoot, or heart failure. List only one to use on each line. mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown is been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? 2 No 1∐ Yes 1 ☐ Yes 26. Place of Death (Check only one) Certification: To Be 25. Was case referred to medical Other: 1 Yes 2 No 1 hpatient 2 ER/Outpatient 3 DOA $4 \,\square\,\, \text{Nursing Home} \quad 5 \,\square\,\, \text{Residence} \quad 6 \,\,\square\, \text{Other } \textit{(Specify)}$ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Naturai (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif

State Registrar

DHMH 17 Rev 1/2001

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

31. Date filed (Month, Day,

32. Registrar's Signature

2348

JANUARY

RICHARDSON

FLORENCE

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of reality and mental rygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show and injury or other traumatic event, the Medical Examiner must be notified at one.	To Be Completed by Funeral Director
n or Vital Records, P.O. Box 68760,	_ /N	ledical	on: To Be Completed by Physician/Medical Examiner

	1 - State Registrar	Certifi	cate of D	Death	Reg. No. 2008 01258								
	Decedent's Name (First, Middle, Last)	-			2. Date of Death Month Day Year 3. Time of Death								
ian cal	Agnes Fay Raynor				Month January		9:17 A M						
car 1er	4a. Facility Name (If not institution, give street and number)	4b.	City, Town, or I	Location of Death	January	4c. County of De							
	26 Crafton Road		Esse	×		Balti	more Co.						
	5. Social Security Number 6. Sex 7. Age (In yrs. last to		Jnder 1 Year Inths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. B	irthplace (State or Foreign Country)						
	212-60-8552 1 M 2 XF 55	Yrs.	nuis Days	Tiodio Inini.	Nov. 2,1		Maryland						
	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	n				10d. Inside City Limits						
_	10a. State 10b. County 10c. City, To	JWII OI LOCALIOI	"				1 ☐ Yes 2 🕱 No						
ctc	Maryland Baltimore			Essex									
Dir	10e. Street and Number	10	Of. Zip Code		10g	. Citizen of What (Country?						
Funeral Director	26 Crafton Road			.221		United S							
nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was I	Decedent of His s, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.						
Ϋ́	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1□Y	res 2⊠ No	Specify:		Specify:							
Completed by		es Decedentia	Llevel Ossuss	tion.	11.40	b Kind of Dunisasa	White						
lete	(Specify only highest grade completed)	(Give kind	s Usual Occupa of work done di IOT use retired)	uring most of worki	ing	b. Kind of Busines	s/industry						
Ĕ	(Specify only highest grade completed) Elementary/Secondary (0-12) Output College (1-4or 5+) Output Homemaker Output Ou												
S	17. Father's Name (First, Middle, Last)	НОШ		18. Mother's Name	(First, Middle, Ma	Own Ho iden Surname)	me						
Be C	17. Father's Name (First, Middle, Last) Lewis T. Oliver 18. Mother's Name (First, Middle, Maiden Surname) Mary Smith												
10		9b Mailing Ad	Idress (Street a		al Route Number, C	City or Town State	Zin Code)						
	Mr. Gregory Raynor (Husband)		afton R		ex, Maryl								
	20a Method of Disposition 20b. Place	of Disposition	(Name of			c. Location - City of							
	1 ☐ Burial 2 【Cremation 3 ☐ Removal from State cemp	tery, cremator	ry or other place	· i		•							
	4 Denation 5 Other (Specify) Hill top Service Corp. 1/23/2008 Towson, Maryland 21. Signature by uneral Service Disease 22. Name and Address of Facility												
	Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222												
23a. Part. Enter the disease, or complications that caused the Math. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition													
													resulting in death) Due to (or as a consequence
	Sequentially list conditions. b.												
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying												
ami	Cause (Disease or injury that initiated events C.												
Ě	Due to (or as a consequence												
Medical Examiner	d												
Mec	IF FEMALE:												
an/	23b. Was decedent pregnant 23c. If yes, outcome pt pregnancy		pic pregnancy			23d. Date of d							
Physician/	in the past 12 months? 1	n 5 ☐ Oth	er (specify)			Month	Day Year						
Phy	9 Unknown												
by	Part II. Other significant conditions contributing to death but not resulting	g in the underly	ying cause give	n in Part I.			to the cause of death?						
ted					1 Tes	2 No 3 □	Probably 4 ☐Unknown						
Completed by					24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of						
ĕ					performe		?						
Be C	25. Was case referred to medical examiner?			26. Place of Death									
ToE	L Hospital	Outpatient 3	□ DOA Othe	r: 4 🗆 Nursing Ho	me 5 Residen	ce 6 □Other (Sp	pecify)						
Ë	27. Manner of Death 28a. Date of Injury 28b. 1 ☑Natural 5 ☐ Pending (Month, Day Year)	b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred							
atic	2 Accident investigation	N		es 2 □ No									
tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, building, etc. (Specify)	, farm, street, f	actory, office	53,466,536	28f. Location (Stre City or Town,		Rural Route Number,						
Š													
Medical Certification:	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occ and/or investi	urred at the tim gation, in my op	e, date and place, pinion, death occur	and due to the cau red at the time, dat	se(s) and manner e and place, and d	as stated. ue to the cause(s)						
Mec	29b. Signature and title of certifier		29c. License	number	290	. Date signed (Mo	nth, Day, Year)						
	Hanet (where mo		Du	6118	-3	an 22	2008						
	30. Name and address of person who completed cause of death (item 23s	a) (Type, Print)) 0	0 1	10 h		1						
	JANET COOPER MD 1447	York	Koa	d Lu	therville	e MD	21093						
ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	. M. a										
rar	IANZ J ZUUS I	E to wheel	Shad										

Regist

08-00568	
Beth Rosemary	

Please Type or Print in Black Indelible Ink. Ensure Ali Copies Are Legible.

Beth Rosemary	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No. 2008 0 25									
Physician Medical Examine	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death									
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4536 Manorview Road 4c. County of Death Baltimore									
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)									
Director	213-88-2676 1 M 2XF 31 Yrs. Months Days Hours Min. Sept. 15,1976 Maryland									
t any	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits									
the Maryland as or 28a-f shoretified at once.	Maryland Baltimore Timonium 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?									
th the M 23a or 2 notified										
r death with or items 23 must be no Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.									
s after of miner n	3 Widowed 4 Divorced If Yes, Give Year or Dates: Yes 2 Y No specify: Specify: White									
6 172 hour an "nate cal Exau	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)									
5-0036 ed within 72 hour tygene. other than "natu the Medical Exan	2 Customer Service Rep. Publishing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)									
215 be fill mtal F rrked ent, 1	Dennis M. Rosemary Elaine M. Knach									
MD 21 3.2 should th and Me 1.27 is ma umatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Informant's Name/Relationship (Type, Print) 19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Baltimore, MD permit Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	20a. Method of Disposition									
Baltimo permit Pag Department Important: injury or ot	1 X Burial 2 Cremation 3 Removal from State Dulancy Valley 4 Donation 5 Other Specify: Memorial Gardens 1-25-2008 Timonium, Maryland 21 Signature of Funda Service Libensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc.									
	1050 York Road Towson, Maryland 21204									
Physician /Medical xaminer	Approximate Interval failure. List only one cause on each line. Immediate Cause (Final disease a. Methadone and all razolam intoxication Approximate Interval Between Onset and Death									
	or condition resulting in death) Due to (or as a consequence of):									
niner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause C.									
uted ansit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.									
60, casecuted hysician and e burial - transit	XUNPENDED X AMENDED 23a,27,28a-f, perME,g876, 2/29/08 TT									
6876 ertificate ding phy e as the t	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year									
D.O. Box 68760, that the death certificate be executed by the attending physician anderached for use as the burial - traby. Physician/Medical	1 Yes 2 No 9 ✓ Unknown 4 Pregnant at time of death 5 Other (Specify)									
P. C	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown									
Records, F The law requires ficate has been sign page 2 should be Completed b	24a. Was an 24b. Were autopsy findings available									
of Vital Records, ng Physician: The law require Nher this certificate has been si nneral director, page 2 should b n: To Be Completed	autopsy prior to completion of cause of performed? death? 1 Ves 2 No 1 Ves 2 No									
Vital ysician: his certif director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No No No No No No No No									
n of ving Ph. After ti funeral on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred									
Division of teal or Attending ans after death. The lived in by the function by the function is a function.	Pending Investigation Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. Pending Investigation Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City									
S 2 3 2 1 C	4 Homicide determined (Specify) found in dwelling 4536 Manorview Rd. Baltimore, MD									
Division To the Hospital or Attention 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the Helical Certification	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
_ / ≥	29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year)									
JGME	30. Name and address of person who completed cause of death (Item 23a)									
State	Mary G. Apple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Begistrar's Signature.									
Registrar	IAN 2 3 2008									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Amend I	tem 26 per ve	ryland / Der erb., g8/5	ertment of H 01/23/08 ertificate of t	ealth and Me hb <i>Death</i>	ental Hygie _{Reg.}	ne 2008	3 01260
	Physicia	an	1. Decedent's Name (First, Middle					2. Date of Death _Month	Day 200 Year	3. Time of Death
-48	/Medic		Richard C. Su			T		Janaury	4, 2008 ear	8:00 P M
	Examin	er	4a. Facility Name (If not institution 2825 Michigan A				Location of Death Ltimore Hi	ohlands	4c. County of Dea Baltin	
	Funeral	4	5. Social Security Number		(In yrs. last birthday) If Under 1 Year	If Under 24 Hrs. 8	B. Date of Birth	9. Bir	thplace (State or Foreign
H	Director		219-32-8042	X □M 2□F	73 Yrs.	Months Days	Hours Min.	ep. 11,	1934 Ñ	Maryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	laryla shov sd at	'n			100. Oily, TOWN OF L		. 114 -1-1 4			1 □Yes 2 No
	the N 28a-i	rect	MD Balt 10e. Street and Number	imore	<u>.</u>	10f. Zip Code	e Highland		. Citizen of What Co	ountry?
	n with	Funeral Director	2825 Michigan A	venue		21.2	227	U	nited Sta	ates
	deatl	ner	11. Marital Status	12. Was Decedent E	ver in U.S. 13	. Was Decedent of Hi If Yes, specify Cuba	Ispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	14. Race - Ame Black, Whit	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2□ Marri 3 ሺ Widowed 4 □ Divorced		0	1 □ Yes 2 No	Specify:	, ,		White
21215-0036	n 72 ho "natur edical	Completed	15. Decedent (Specify only highes	st grade completed)	(Giv	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of working f)	g 16	b. Kind of Business	/Industry
75	I withi jiene. r than the M	E O	Elementary/Secondary (0-12)	College (1-4or 5+) [Computer (_		Social	Security
פַ	e filed al Hyg other vent,	BeC	17. Father's Name (First, Middle,	•	•		18. Mother's Name		•	
<u>la</u>	should be ind Mente s marked umatic ev	2	Richard Theodor	e Sullivan					lie Benne	
Mar	ind 2 sho alth and 27 is ma er trauma		19a. Informant's Name/Relationsl Donna Fitzgeral	and Number or Rural Rd., Glen						
altimore,	Pages 1 annent of He ant: If item ary or othe	Richard Theodore Sullivan State Part							Town, State	
를	4 □ Donation 5 □ Other (Specify) Park 1-9- 21. Signature of Pare and Address of Facility Am								len Burni eral Home	
Ba	21. Signalure of Princial Service Drugsum 22. Name and Address of Facility Am 2719 Hammonds Fry R									
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused to only one cause on each line						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Mv.	o cardia		arAron			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or As a						
9		e.	Sequentially list conditions,	b. Due to for as a	consequence of:					
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	icate be executed physician and s the burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):					
68760,	ate be hysicia he bu	dical		d						
	ertific ling p		IF FEMALE:	23c. If yes, outcome p	of prognancy					
Bo	res that the death certifigned by the attending be detached for use a	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	☐ Fetal death 3	Ectopic pregnancy	1		23d. Date of de Month	Day Year
o.	the d	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
٠ <u>,</u>	s that ned b	by Pi	Part II. Other significant condition	ons contributing to death bu	t not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	cco use contribute t	to the cause of death?
ğ	w require been sig should b	edb						1 ☐ Yes	2 ⁄ No 3 □ P	robably 4 Unknown
Records, P.O. Box	e la has je 2	Completed						24a. Was an autopsy performe	prior to death?	
		Be Co	25. Was case referred to medical				26. Place of Death		ZNo 1 ☐ Ye	s 2021 No
>	ding Physician: n. After this certific funeral director,	To B	examiner? 1 ☐ Yes 2MX No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpati	ent 3 DOA Oth	er: 4□ Nursing Hom	ne 5 Residenc	ce 6 Exother (Sp.	ecify outside
O to the second of the second										
<u>Si</u>	ttendi leath. ttor: A	cati	2 Accident investig 3 Suicide 6 Could i	gation	ny - At home farm s	M 1 □	Yes 2 □ No	9f Location (Stree	et and Number or F	Tural Route Number,
Division or Vital	al or Ais after of al Direct	Certification:	4 ☐ Homicide determ	building, etc.	(Specify)	street, factory, office		City or Town,	State)	aran lodio rambol,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	Medical C	29a. Certifier (Check only one) 1 Certifyir 2 Medical	ng Physician: To the best of Examiner: On the basis of and manner stat	examination and/or	ath occurred at the tir investigation, in my o	me, date and place, a ppinion, death occurre	and due to the cau ed at the time, date	se(s) and manner a e and place, and du	as stated. se to the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and title of certifie	1 (1)		29c. Licens		1	. Date signed (Mor	
			1 that	J. Julita	MU,	1 DZ	3365	J	annary 7	,2008
(2	41)		30. Mame and address of person	Thirte M.D. 4	ath (Item 23a) (Type	e, Print) Rd	3365 #202,	Balton	on, MO	21228
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	A. s		- 1.		
	3		AWIN WO CO	por son Son	TO AND THE PERSON NAMED IN	Bangier				

DHMH 17 Rev 1/2001

08-00360 Earl R. Small, II

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		Registrar	ate of Death	1	R	eg. No.	8 0125			
Physicia	in/	Decedent's Name (First, Middle,Last)			2. Date of Dea Month	Day Year	3. Time of Death 0620 hrs			
Medical Exami		EARL ROBERT SMALL, II 4a. Facility Name (if not institution, give street and number)	4h City To	own, or Location of D	January 1	3, 2008 4c. County of Deat				
		Anne Arundel Medical Center	Annap		76401	Anne Arundel				
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday) If Under	r 1 Year If Under 2	4Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bi				
Director		219 79 1298 1XM 2 F	Yrs. Months	Days Hours	Min. 10/15	/2007 Forei	ountry) MD			
	ŀ	Usual Residence of Decedent								
w any		10a. State 10b. County 10c. City, Town					10d. Inside City Limits 1 Yes 2 X No			
yland -f sho	g	MD ANNE ARUNDEL RIVA 10e. Street and Number	10f. Zip (Codo		10g. Citizen of What Cou				
e Mar or 283	Direc			1140		UNITED ST				
215-0036 be filed within 72 hours after death with the Maryland nual Hygiene. rked other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once.	필	3064 PERCH DRIVE 11. Marital Status 12. Was Decedent Ever in U.S.			? (Specify Yes or N		rican Indian, Black,			
r death with or items 23	uneral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		Cuban, Mexican, P		White, etc.				
	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2	X No specify:			HITE			
hours natur Exami	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)									
36 iin 72 fran "dical]	plet	College (1-4 or 5+)	NONE			NONE				
5-00 led with Hygiene other t	Complet	17. Father's Name (First, Middle, Last)	HOHE	18.Mother's	Name (First, Middle,					
21215-0036 July be filed within 72 hours after Mental Hygione. marked other than "natural", event, the Medical Examiner	Be (EARL ROBERT SMALL, SR.	V. 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 - 100 -	JESS	ICA LORRA	INE HELLER				
	٤	1-	-	•		mber, City or Town, Stat	e, Zip Code)			
nd 2			064 PERCH		RIVA, MI	20c. Location - City o	r Town, State			
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 injury or other traur		1 Burial 2 X Cremation 3 Removal from State crema	atory or other place)							
Baltimo permit. Page Department (Important: injury or ott		4 Donation 5 Other Specify: METRO 21 Signature of Funeral Service sicensee	POLITAN C							
Ba Depa Imp		T. T. Maushl		L'S FUNER UITLAND RO		F MARYLAND, TLAND, MD_2	INC. 20746			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do a failure. List only one cause on each line.	not enter the mode of	f dying, such as care	diac or respiratory a	rest, shock, or heart	Approximate Interval Between Onset and			
/Medical aminer	9 4	Imm late Cause (Final disease a. Sudden Unexpla	ined Deatl	h In Infa	ncy (SUDI)	Death			
		or condition resulting in death) Due to (or as a consequence of):								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
	Examiner	C. Due to (or as a consequence of):								
nd uted		events resulting in death) Last Due to (or as a consequence or): d.								
760, cate be executed physician and he burial - transi	Medical	X UNPENDED AMENDED 23a, 27,	28a-f per	me g877	3-21-08 v	t				
		IF FEMALE: 23c. If yes, outcome of pregnance 23b. Was decedent pregnant in the		0		23d. Date of delive				
Box 68 death certif the attending	cian	past 12 months? 1 Live birth Pregnant at time of death	Fetal death Other (Spec	3 Ectopic p	огеднансу	Month	Day Year			
Records, P.O. Box 68' The law requires that the death certificate has been signed by the attending page 2 should be detached for use as:	Physician	1 Yes 2 No 9 Unknown g Unknown		"						
P.O. es that the igned by	by P	Part II. Other significant conditions contributing to death but not result	ing in the underlying	cause given in Part		tobacco use contribute tes 2 No 3 Pr				
cords, P.O. law requires that has been signed b	edt						autopsy findings avaitable			
: ord aw rec has bee 2 shou	ple				aut		completion of cause of			
tal Rec tian: The l certificate l	Completed				1 ✓ Yes	2 No 1 🗸	Yes 2 No			
ician: s certif	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/		Other	Nursing Home 5	Residence 6 Oth	er:			
n of Vital I Jing Physician: After this certifi funeral director,	. To	27. Manner of Death 28a. Date of Injury 28b		28c. Injury at Work?		e how injury occurred				
	5 1 Natural 5 Pending 1-13-2008 5:00am 1 Yes 2 x No unknown									
ivision or Attenuter death Director:	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home,		, office building, etc.	28f. Location or Town		Rural Route Number, City			
Ospital ospital hours a uneral J	Cert	4 Homicide determined (Specify) reside			3064 P	erch Dr. Ri	•			
± 2 ₹ 5		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/o	leath occurred at the r investigation, in my	time, date and place opinion, death occu	e, and due to the ca urred at the time, da	use(s) and manner as st e and place, and due to	ated. the cause(s)			
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier		. License number		29d. Date signed (M				
	-	1/1 1/1 1/1 a m		O.C.M.E.	OCME	January 14, 20	08			
		30. Name and address of person who completed dause of death (Item 23a								
(0)		Theodore M. King, Jr., MD. Assistant Medical Example 1		enn Street, Balt	imore, MD 212	01				
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	S. S. Sand							
Regis	trar	JAN 6 0 LOO	him Bala							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day S **Physician** enise 2008 pharron /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner evindale NUISING 9. Birthplace (State or Foreign last birthday **Funeral** Months 217-64-7607 iland Director Usual Residence of Decedent Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or one one other traumatic event, the Medical or other traumatic event event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2☐ Married 1 ☐ Yes 💹 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) stude 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. d 20c. Location - City or Town. St 20a. Method of Disposition 20b. Place Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 21. Signature of Funeral Service Licensee ing, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mulhinle **Physician** bononel disease or condition resulting in death) /Medical Due to (or as a conseque e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown cate has been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death | Check only or Be Hospital: 1 Hopatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 TYes 2 No ပ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of De th 28c. Injury at Work? Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A death. 🖊 🗌 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) In Adredore are 2434 31. Date filed (Month, Day, Year) JAN 2 3 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANHARY 7 2002 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 218-60-6140 Usual Residence of Decedent Director Augus 112, 1955 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MIS 10e. Street and Number 10g. Citizen of What Country? by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BALL 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic areas. Elementary/Secondary (0-12) College (1-4or 5+) 10Th. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Unknows UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EdWARd 5more M1 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CARMEL COM SANVARIZZZOT 21. Signature of Fune FI Service Licensee EARN'NE CAROLINE 170,MD. 212 1121N. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Esophageal e to (or is a consequence of): **Physician** /Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) been signed by the s 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No Stokes 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Eutaw St Baltimore, MD 21201 Hospice 838 Kichey 31. Date filed (Month, Day, Year) JAN 2 3 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			State of Maryland / Depa	rtment of Health and M	-	ne 008	01264		
	Physici /Medic		Decedent's Name (First, Middle, Last) HELEN IRENE SCI	HMIDT	2. Date of Death Month 20,	^{Day} 2008 Year	3. Time of Death 2:30 P M		
}	Examin		4a. Facility Name (If not institution, give street and number) Mariner Health of Glen Burnie	4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Aruno	le1		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 79 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye July 17,	9. Birthol Count 1928 Mary	ace (State or Foreign try) y Land		
	show	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc Maryland N/A Ba.	cation 1timore		10	0d. fnside City Limits 1 Yes 2 No		
	with the Ne or 28a-f	Director	10e. Street and Number 1453 Henry St.,	10f. Zip Code 21230	10g.	Citizen of What Coun			
36	rs after death I', or Items 23	by Funeral	1 Never Married 2 Married 1 Yes 2 X No	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto ☐ Yes 2⊠ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any injury or other treumetic event, Ite Medical Examiner must be notified at once.	Completed t	(Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+)	ent's Usual Occupation kind of work done during most of worki OO NOT use retired)	ng Ho	ousewife & Mother aiden Surmame) ne Virginia Delker City or Town, State, Zip Code) exas 78641 oc. Location - City or Town, State altimore, Maryland ome, P.A. Md. 21230			
/land 2		To Be C	17. Father's Name (First, Middle, Last) William Howard Ohl		(First, Middle, Mai Catherin		Delker		
				g Address (Street and Number or Rura Parkwood Dr., Le					
Baltimore,			'4 □Donation 5 □Other (Specify) Cedar Hi	natory or other place) 11 Cemetery 1/23	/08 Ba	ltimore, M			
Balt	permit. Depart Import any inj		21. Signature of Fundral Service Licensee Kevin E Ecker 22.	uneral Ho Balto., M	me, P.A. d. 21230				
760,	/Medical Application and Appli	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	The mode of dying, such as cardiac of DEMEA	r respiratory arrest,	ENSION	Interval Between		
P.O. Box 68	The law requires that the death certificate b Ite has been signed by the attending physic bage 2 should be detached for use as the b	by Physician/Medical		Ectopic pregnancy Other (specify) derlying cause given in Part I.	II.	co use contribute to the	Day Year e cause of death?		
Il Records,		Completed			1 Yes 24a. Was an autopsy performed 1 Yes 2	24b. Were autop prior to con death?	ably 4 Unknown by findings vailable poletion of cause of		
Division of Vital	ding Pl	Certification: To Be	25. Was case referred to nedical examiner? 1	28c. Injury at Work? M 1 Yes 2 No	ne 5 Residence 28d. Describe how i	t and Number or Rural			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Cer	29a. Certifier (Check only one) Medical Examiner: On the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or inviging and manner stated.	occurred at the time, date and place, a estigation, in my opinion, death occurre	and due to the caus ad at the time, date	e(s) and manner as sta and place, and due to	ated. the cause(s)		
}	To the within 2 To the comple	Mec	29b. Signature and little of certifice.	29c, License number	O JA	Date signed (Month, D	2008		
	5		30. Name and address of person who completed days of death (Nem 23a) Type. (MORE MA	CHIE	TIGHW	AY		
l.	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 3 2008		(011	12			

DHMH 17 Rev 1/2001

			Flease	State of Manua							_			
			For State	State of Maryla	•		te of L				211118	101	266	
			Registrer 1. Decedent's Name (First, Middle, Lateral Lat	st)		unca	ie oi L	Jean	2. Date of Dea	Reg. No	d,_	3. Time	of Death	
Н	Physici			INGRAM STEWAR	T. SR.				January	Da	y Year 200	1 2000	30 PM	
ė.	/Medio Examir		4a. Facility Name (If not institution, give		, 5111	4b. Cit	y, Town, or	Location of Death			c. County of De			
	Exami		Union Memorial H	Hospital		Ва	altimo	ore			Nz	'A		
	Funeral		5. Social Security Number 6. S	7-8 · · · - · · -	rs. last birthday,	If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year	9. B	irthplace (State Country)	or Foreign	
	Director		181-09-4976	Mw 501	90 Yrs.				Apr 2,	19	17 Ne	w Jers	<u> </u>	
	land		10a. State 10b. County	10c.	City, Town or L	ocation					· · · · · · · ·	10d. Inside	City Limits	
	Mary	ţ	Maryland N/	A	Balti	more						1 ሺ Y	es 2□No	
	h the	<u>le</u>	10e. Street and Number				ip Code			10g. C	itizen of What (Country?		
	th wit	by Funeral Director	1286 Cedarcroft	Road				21239			USA			
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mentalle Hygiene. Department of Heelth and Mentalle Hygiene. The marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Espainer must be notified at Appea.	neu	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Dec	edent of Hi	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	-	14. Race - An Bfack, Wh	nerican Indian, nite, etc.		
36		Y.	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No W	WII	1 🗆 Yes	2 ∑ No	Specify:			Specify:	White		
Maryland 21215-0036		ed b	15. Decedent's E	Year or Dates:	16a Dece	dent's Us	ual Occupa	ation	<u> </u>	16b k	Kind of Busines			
7.	n "ne	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)	(Give	kind of v	vork done d use retired,	furing most of wor	king	100.1		,		
212	d with	Completed	Elementary/Secondary (0-12)	Coffege (1-4or 5+) 2 yrrs	Seli	f Em	loyed	1		T	V Repai	r		
힏	e file e Hy i oth	Bec	17. Father's Name (First, Middle, Last,)				18. Mother's Nam	ne (First, Middle,	Maide	n Sumame)			
yla	Ment Ment arked atic	2	John Stewart					Sarah	McEl					
Nar	2 sho		19a. Informant's Name/Relationship (and Number or Ru						
e)	1 end 4eelth em 27 ther t		Mrs. Valerie Lynn 20a. Method of Disposition		ter) 230 b. Place of Disp)3 Kr	oll (Court, Ja	rrettsv.	ille	Le, Maryland 21084 Location - City or Town, State			
פֿר	in it of h		1 ☐ Buriaf 2 💆 Cremation 3 ☐	Removal from State	cemetery, cre	matory or	other place							
Baltimore,	it. Partituder		4 □Donation 5 □Other (Specifical Signature) of Funeral-Service (Liber					tory 1/22 is of Facility	2/2008	Bal	timore,	Maryl:	and	
Ba	Depa Impo any i								FUNERA	L HO	OME, IN	C.		
			Martin D. Law 23a. Part. Enter the disease, or com shock, or heart failure. List only	plications that caused the d	leath. Do not en	ter the m	YOCK ode of dying	Koad , Ba g, such as cardiad	Ltimore or respiratory ar	rest,	aryland	21212 Approxim	nate	
	Physician		Illillediate Cause (Filla)	one cause on each line.	+		bl	11.00				Onset an	nd Death	
	/Medical		disease or condition resulting in death)	a. Intrave Due to (or as a con		ay	D_I	eeding					CEKR	
	Examiner		Conventially list conditions	, Hyperter	nsion							Sever	al year	
	۳۱. / ۳	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	sequence of):									
	trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
60,	be executed icien and burial-transit	cal E)	josannig in dozin, czsk	Due to (or as a con	sequence or):									
_	w requires that the death certificate be executed been signed by the ettending physicien and should be detached for use as the burial-transit	g	•	d										
Вох 68	The law requires thet the death certificate ste has been signed by the ettending phys page? should be detached for use as the	Physician/Medi	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	gnancy						23d. Date of c	elivery		
	death e etter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		□Ectopic □ Other (pregnancy specify)				Month	Day	Year	
o.	t the c	hys	9 Unknown	9□ Unknown										
Division of Vital Records, P.O.	os the	by P	Part II. Other significant conditions of	contributing to death but not	resulting in the t	underlying	cause give	en in Part I.	23e. Did to	obacco	use contribute	to the cause of	of death?	
ğ	en sig	ed							101	Yes 2	2 □ No 3 □	Probably 4	⊘ Unknown	
ဝင္ပ	e 2 C	Completed							24a. Was		24b. Were	autopsy finding	gs available	
m —	The ete h	E C							perfo	rmed?	death	? es 2□ No		
/ita	cian: artific actor,	Be (25. Was case referred to medicat examiner?						ith (Check only o	ne)				
5	shysis this o	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient				4 Nursing n	ome 5 Resid			oecify)		
ă	fing F After funer	o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	of M	28c. Injury Work	/at <br Yes 2 □ No	28d. Describe h	now infi	ury occurred			
Sic	Attending Physician: ir death. ector: After this certifice by the funeral director, I	Icat	2 Accident investigation 3 Suicide 6 Could not b	e Con Steen of friend	At home farm st			765 2 140	28f. Location (S	Street a	and Number or	Rural Route N	umber	
<u>></u>	after Dire	Certification:	4 Homicide determined	building, etc. (Sp		.,, ,,	sry, omoc		City or Tox	wn, Sta	te)			
	spite hours ineral y filled		29a. Certifier 12 Certifying Pt	nysicien: To the best of my	knowledge, dea	th occurre	ed at the tim	ne, date and place	, and due to the	cause(s) and manner	as stated.		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exar	niner: On the basis of exan and manner stated.	nination and/or it	nvestigatio	on, in my op	oinion, death occu	rred at the time,	date ar	nd place, and d	ue to the caus	3(S)	
	To t To t	M	29b. Signature and title of certifier	00 11.	A 4 10	2	9c. License			-9	ate signed (Mo			
!	/1		▶ Danna]	radiatal,	M.D.		A1-	24389	46-H3	J	anuar	y 20,	2008	
	8		30. Name and address of person who	1 1 2 . A			M -		Ha= 1	ايرا	Mr			
~	Sta	to		to tay, M.		nion	rien	norial	ПОЗВІТ	ial	, M.D	0		
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 3 2001	B Alexander	1 Lans	K								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

			For State Registrar		,	Cei	rtificate of	Death		Reg. No.	2000	01201
100	Physicia	an a	1. Decedent's Name (First, Middle,	Last) John	Por	+ 0.35	Somers		2. Date of De Month			
- 1	/Medic	_			POL	cer		-1	Janua		, 2008	11:52P ^M
	Examin	er	4a. Facility Name (If not institution, and I E Turtle Cou				4b. City, Town, o	emere	eam		County of Death	e Co.
	Funeral				e (In yrs. la	st birthday)	If Under 1 Year Months Days			th		lace (State or Foreign try)
£.	Director		358-01-4537	1 🛣 M 2 🗆 F	89	Yrs.	Months Days	Tiodis III	Feb. 1			yland
	land tr		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	Mary a-f sh ffied a	ior	Maryland B	altimore					Edgeme	re		1 □Yes 2≹ No
	ith the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Coun	itry?
	ath w		1 E Turtle Co			140	21219		(2		ited Sta	
	ter de iner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent I Armed Forces? 1 ★★Yes 2□1					(Specify Yes or No lerto Rican, etc.)	- '	Black, White,	
5-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. then "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:	IWW	I	1⊡Yes 2 [®] ⊡No	Specify:			Specify: Wi	nite
<u>က</u>	72 ho 'natur dical	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done	during most of v	working	16b. Kin	d of Business/Ind	dustry
2	within ene. than '	ldw	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT use retire inet Make	•		Car	pentry	
2 0	filed v Hygik other i	Be Co	9 Years 17. Father's Name (First, Middle, La	nst)		Cab	THEC MAKE		Name (First, Middle		<u> - </u>	
Maryland	uld be Mental rrked c	To B	Julian C. Son	ners				Goldi	ie B. Bea	1		
lar)	ss 1 and 2 should of Health and Men item 27 is marke other traumatic	•	19a. Informant's Name/Relationship				•		Rural Route Numb			•
	t and Health Pm 27 ther tr		Barbara Kelly 20a. Method of Disposition	(Niece)	20h Pla		Cherry Va	alley Ro	Date Reis		cation - City or To	
altimore,	Pages nent of I int; If ite		A Burial 2 ☐ Cremation 3	_	ce	metery, crei	matory or other pla Cemetery	ce) / 1,	/22/2008		,	Maryland
		i	4 □ Donation 5 □ Other (Special Signature of Funeral Service Li			22	2. Name and Addre	ess of Facility	al Home o	F Dun	dalle Ti	-
ñ	permit. Departr Importa any Inji once.	1	Vento a	Conse-			7922 Wis	e Ave.	Dundalk	Mar	yland 21	L222
	Ac.		23a. Part1. Enter the disease, or c shock, or heart failure. List of	inplications that caused by one cause on each lin	the death.	Do not ent	er the mode of dyi	ng, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.	Con	gest	in 4	ext 1	arlen			2 week.
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	nce of):	14 11	211	andi Us	21.1.	1.5	10 %
Ž,	14. Br	Jē.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due for as	a consequ	ence of):	fuer pri	11/2 0	with the same of t	·	1302	, Ju
H	ransit	Examiner	that initiated events	с	_							
, 20,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):						
68760,	rtificate be executed ng physician and s as the burial-transit	Medical		d								
POX	leath certii attending i for use a	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			∃Ectopic pregnanc	.,		2:	3d. Date of delive	ery
о С	e deat	Physician/	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant at			Other (specify)	у			Month	Day Year
J O	law requires that the death oe as been signed by the attendi 2 should be detached for use	Phy	9 ☐ Unknown Part II. Other significant condition		ut not resul	ting in the u	nderlying cause giv	ven in Part I	23e Did	ohacco us	se contribute to the	ne cause of death?
Vital Records,	w requires that s been signed b should be deta	d by	Atril L	brillation	4	ung in the d	nderlying dadde gr	on an area.		Yes 2□		/
င်္ပ	w required	Completed							24a. Was	an	24b. Were auto	psy findings available
2	sician: The law certificate has b irector, page 2 s	omp							— auto		prior to co death? 1 ☐ Yes	psy findings available mpletion of cause of 2□ No
<u>E</u>	ertifica ctor, p	BeC	25. Was case referred to medical examiner?	The second			V=V=	26. Place of I	Death (Check only			20.10
٥ >	hysic this ce	မှ	1 Yes 2 No				II 3 DOA		g Home 5 Res			y)
5	ding F	ion:	27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investiga	28a. Date of Inju (Month, Day	y Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2 ∐ No	28d. Describe	now injury	occurred	
DIVISION	Atter deatector by the	fical	3 Suicide 6 Could no	t be 28e. Place of inju	ıry - At hor	ne, farm, str	reet, factory, office					al Route Number,
5	s fter al Dire	Certification:	4 ☐ Homicide determin	building, etc	с. (ъреспу,	/			City or 10	wn, State)		
	To the Hospital or Attending Physician: within 24 hours After deah. To the Funeral Director After this certified completely filled in by the funeral director, g	edical ((Check only 2 Medical E	Physician: To the best caminer: On the basis of	f examinati							
	thin 2	Med	29b. Signature and the of pertifier	and manner sta	ated.		29c. Licens	se number		29d. Date	e signed (Month,	Day, Year)
	F 2 5 8		1 /ach	11		- la		3055	_		18	
,	171		30. Name and address of person w		eath (Item	23a) (Type,	Print)					
_	4,		Alan N. Dennis,				Road Edg	gemere,	Maryland	212	19	
100	Sta	40	31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure :	9					

Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

Year)

Ragistrar's Signature

			For State Registrar	State of Ma	liylall		rtificate d			niai mygi Re	g. No O	38	01269	
	Dhyaisi	1	1. Decedent's Name (First, Middle, Las	st)		_			2.	Date of Death Month		Year	3. Time of Death	
	Physici /Medic		EDWARD SHAW						JA	NUARY	8, 200	8	8:30p M	
	Examin	er	4a. Facility Name (If not institution, give					n, or Location	of Death		4c. County			
. -	<u>-</u>		FUTURECARE HOM 5. Social Security Number 6. S		(In vrs I	ast birthday)	BAL'I	IMORE ar If Under	24 Hrs. 8	Date of Birth		/A	place (State or Foreign	
2	Funeral Director			M 2□ F	45	Yrs.	Months Da		Min.	Date of Birth (Month, Day, 11–19–	Year) 1962	Cou	ntry) RYLAND	
	yland now at		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside City Limits	
	e Mar Sa-f sl tified	Director	MD. N/A		В	ALTIMO	RE						1X Yes 2 □ No	
	or 28	Dire	10e. Street and Number				10f. Zip Cod			10	· ·	. Citizen of What Country?		
	eath v is 23a must	eral	721 N. CAREY S	12. Was Decedent B	ver in II	S 13 1	212		igin? (Specif	y Voc or No.	USA 14 Bac	e - Americ	can Indian,	
0000	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			Was Decedent If Yes, specify (1 ☐ Yes 2🎇			an, etc.)	Blac	ck, White,	etc.	
2	72 hours "naturai"; edicai Exa	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	dent's Usual Oo kind of work do DO NOT use re	ne durina mos	st of working	1	16b. Kind of Bu	. Kind of Business/Industry		
7	within iene. than " the Med	dmc	Elementary/Secondary (0-12) -11-	College (1-4or 5 -0-	+)		STODIAN	urea)			TR	ASH		
0	i Hiled i Hygi other ent, t	Be	17. Father's Name (First, Middle, Last)			000	JODIAN.	18. Mothe	er's Name (F	irst, Middle, M			-	
	Aentai Aentai rked o tic eve	To B	JUNIOR SHAW					s	ARAH C	CREECY				
Viary	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Str	eet and Numb	er or Rural R	loute Number,	City or Town,	State, Zij	Code)	
où Où	and in 27 m 27		SARAH SHAW (MOT	HER)	look D		W. LAI		AVE.	BALTIM	ORE, M	ARYL/	AND 21217	
_	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2/☐ Cremation 3 ☐				osition (Name or matory or other		Date		ALTIMORE, MARYLAND			
Dallillo	+ E E E = .		4 □ Donation 5 □ Other (Specifical Services Licental Services Lic	'			CEMETE Name and Ac		1-22-2			-		
מ	permi Depa Impo any ir		Jaat	V. His	300	1	721-27	N. MON	ROE SI	BALT	IMORE,	•	YLAND 21217	
	* *		23a. Part1. Inter the disease, or come shock, or heart failure. List only	plications that caused one cause in each lin	the death e.	n. Do not ent	er the mode of	dying, such as	cardiac or re	espiratory arre	est,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final dise se or condition resulting In death)	a. Due (or as	EST	1VF	TONLI	Fori	mt				3/15	
	Examiner			Con	n/Why	Mu A	MM	Oners	net					
Un		ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	consequ	uence of):	0							
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Hhax	can	c 16	ESTIN	mony 1	(497 M	Ni				
00	tificate be executed g physician and as the burial-transit		resulting in death, Last	Due to (or as	a consequ	ience of):		•						
00/00	physi physi the l	edical		_d										
O. DOX 0	sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown									23d. Date of delivery Month Day Year		
ŗ	s that ned by e deta	by Phys	Part II. Other significant conditions of	ontributing to death bu	it not resu	ulting in the u	nderlying cause	given in Part I	l.	23e. Did tob	acco use cont	ribute to t	the cause of death?	
ő	en sig									1 □ Ye	s 2 No	3 🗌 Prol	bably 4 Unknown	
II necorus,	The law recate has be page 2 sho	Completed								24a. Was an autopsy perform 1∐ Yes 2	v	prior to co death?	opsy findings available ompletion of cause of 2 No	
NICA NICA	ician: certifik ector,	Be	25. Was case referred to medical examiner?	Hospital:				A.I. /	,	Check only one				
5	Phys r this ral dir	: To	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatie		ER/Outpatier 28b. Time o	IL 3[] DOA	4-24 Ni		5 Reside			fy)	
	th. : Afte	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		njury at Work? I∐Yes 2□		50001150 110	Williamy Goodin	.00		
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Certification:	3 Suicide 6 Could not be determined	28e, Place of injubuilding, etc	ry - At ho :. (Specify	me, farm, str	reet, factory, off	ce	28f.	Location (Str City or Town		er or Run	al Route Number,	
	e Hospit 24 hours e Funera letely fille	Medical (29a. Certifier 1 Certifying Ph	ysician: To the best on niner: On the basis of and manner sta	examinat	wledge, deat tion and/or in	h occurred at the	e time, date ar ny opinion, dea	nd place, and ath occurred	d due to the ca at the time, da	use(s) and ma	anner as s and due t	stated. to the cause(s)	
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Lic	ense number		29	d. Date signe	d (Month,	Day, Year)			
			* Tolar	m 1	2		(Type, Print) T Sav F 30							
	1		30. Name and distribution of person who	completed cause of de					- 5 0	0				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra			nu st	ZNI (C	308	Caro	men	E, V	~2120/	
	Registr	ar	JAN 2 3 2008	Jan Ball Ball	and a street	19034	St. M.							

		- For	State of M			nk. Ensure / of Health and		-	a.	
		1 - State Registrar			Certificate			Reg. No. 200		
Physici		1. Decedent's Name (First, Middle, Miriam A. Solom	ŕ				2. Date of De Month		3. Time of Death 8 11:27 a ^M	
/Medi Èxamir		4a. Facility Name (If not institution,				vn, or Location of Deat		4c. County of D		
	*	Suburban Hospit 5. Social Security Number		je (In yrs. last birth	Bethes		8. Date of Bir	Montgor	mery * Birthplace (State or Foreign	
Funeral Director		052-18-2161 Usual Residence of Decedent	1□ M 200E			ays Hours Min		ay, Year)	Country) ew York	
aryland show dat	Ļ	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 ☐ Yes 2 No	
the Ma 28a-f	Director	MD Montgom	ery	Rockvil	1e 10f. Zip Co	de		10g. Citizen of What Country?		
th with 23a or 1st be	al Di	1801 E. Jefferson	n St. #329		20852			USA	c Country.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give 7 Year or Dates:	Ever in U.S. No	13. Was Decedent If Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puel No <i>Specify:</i>	Specify Yes or No rto Rican, etc.)	14. Race - A Black, V Specify:	American Indian, White, etc. White	
nin 72 hou in "nature Medical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)	(Decedent's Usual O Give kind of work o life. DO NOT use r	ccupation lone during most of wo etired)	orking	16b. Kind of Busine		
ed with ygiene ner tha t, the I	Com		5+		Economis			Governmen	ıt	
d be fill ental H ced oth c even	Be	17. Father's Name (First, Middle, La Abe Abramowitz	ast)			18. Mother's Na Yetta S		, Maiden Surname)		
shoul	ျှ	19a. Informant's Name/Relationship	(Type, Print)	19b. l	Mailing Address (St	reet and Number or R		er, City or Town, Sta	ite, Zip Code)	
1 and 2 Health Im 27 i		Eugene Solomon/s	son	470	04 Longho Disposition (Name of	rn Drive B				
ages ent of l nt: If ite	!	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemetery	, crematory or othe	rplace) ¦	Date	20c. Location - City Beltsvill	•	
epartm epartm nportar ny injui		21. Signature of Funeral Service Li		Noo382	22. Name and A	atory 1/2 ddress of Facility	2/2000	33 Gist A		
	Н	23a. Part1. Enter the disease, or co	Emmun	the death Dono	Rapp Fun	eral & Cre	mation S	vc:Silver	Spring MD Approximate	
Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each li	ne. Ation pne a consequence of	umonia	dying, such as cardio	or respiratory at		Interval Between Onset and Death	
Examiner		Sequentially list conditions	b.	a consequence of	<i>,</i> .					
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
te be executed ysician and ie burial-transit		that initiated events ' resulting in death) Last	C Due to (or as	a consequence of						
icate be physici s the bu	dical		d							
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the light of the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23d. Date of Month	f delivery Day Year						
ires that the de signed by the a I be detached f	by Ph	Part II. Other significant condition	s contributing to death b	ut not resulting in t	he underlying caus	e given in Part I.	23e. Did to	obacco use contribut	te to the cause of death?	
w require been sig should b							10,	Yes 2 No 3	Probably 4 Unknown	
sician: The law s certificate has bo irector, page 2 sh	Completed						24a. Was autop perfo 1□ Yes			
/siciar s certif director	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ent 2 ☐ ER/Outp	atient 3□ DOA	Other: _	ath (Check only o	one) dence 6 □Other (Specify)	
ding Physician: After this certific funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Tir	ne of 28c.	Injury at Work?		how injury occurred	эрвину	
To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 290 Place of init		n, street, factory, of	1 ☐ Yes 2 ☐ No fice	28f. Location (S City or Tov		or Rural Route Number,	
he Hospitu n 24 hours he Funera pletely fille	Medical C	29a. Certifler (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis o and manner sta	f examination and/	death occurred at the for investigation, in	ne time, date and plac my opinion, death occ	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)	
To t Within	Σ	29b. Signature and title of certifier	70			cense number		29d. Date signed (M	fonth, Day, Year)	
	-	30. Name and address of person wh	to completed cause of d	eath (Item 23a) (To	D6 2	949	1	/20/2008		
Oj		Haag Natasha, M	8600 0	ld George		d: Bethesd	a. MD 20	0814		
Sta Registr	_	31. Date filed (Month, Day, Year) JAN 2 3 20	32. Registr	ar's Signature	we's	y				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For Stata Registrar	State of Ma	ryland / Dep			lental Hygi	ene 0 0	8 01272
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month		3. Time of Death
1	/Medi			William	Albert	Singletor Singletor		01	19 200	1/30 A M
	Examir	er	4a. Facility Name (If not institution, give	11 .11 1			r Location of Death		4c. County of	
1			5. Social Security Number) 6. Se	Hospital U	(In yrs. last birthday	「TOSE」(If Under 24 Hrs.	8 Date of Birth		Birthplace (State or Foreign
	Funeral Director			-	72 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, MAY 11,	1935	Birthplace (State or Foreign Country) Maryland
			Usual Residence of Decedent						2303	Tate y rand
	anylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	the Ma 28a-f	cto	MD Balti	more			sex			1 ☐ Yes 2 X No
	with th	吉	10e. Street and Number			10f. Zip Code	01.001	10	g. Citizen of Wha	
	seth is 23	eral	9 Judywood Lane	12. Was Decedent Ex	var in II S 12	Was Decaded of b	21221	poits Vos as No		SA American Indian,
10	be itled within 72 hours after deeth with the Maryland ital Hygiene. bd other then "natural", or items 23a or 28a-f show event, the Mudical Examinar must be notified at	Funeral Director	1 ☐ Never Married 2 💥 Married	Armed Forces? 1 XYes 2 □ No If Yes, Give)		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		White, etc.
93	ours aff	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1	955-1963	1 ☐ Yes 2X No	Specify:		Specify:	White
2-0	72 hours natural',	Completed	15. Decedent's Edi (Specify only highest grad		16a. Dece	edent's Usual Occup	ation	ing 1	6b. Kind of Busin	ness/Industry
2	ithin Den	nple	Elementary/Secondary (0-12)	College (1-4or 5+)		during most of work	9		
2	led w lygier lygier ther th	S	12			Business			Trucki	ng
anc	ntal H	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, M		
Maryland 21215-0036	d Me mark matic	ဥ	George 19a. Informant's Name/Relationship (T)		ngleton	ing Address (Street	Grace and Number or Run		Founds	Ÿ
Za	od 2 s lith an 127 is r trau		Virginia G. Sin 1			dywood La		sex, MD	21221	16, 21p Coue)
e,	ges 1 and 2 should be filed within 7 to f Health and Mental hygiene. If item 27 is marked other then "n or other traumatic event, I're Mod		20a. Method of Disposition		20b. Place of Disp	osition (Name of				ty or Town, State
E	Page tent o int: if		1 ☐ Burial 2 【XCremation 3 ☐ § 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State			$\operatorname{Inc} \int 01/2$	21/08	Baltimo	ore. MD
Baltimore,	permit. Pages 1 Department of H important: if ite any injury or ot		21. Signature of Funeral Service Licens	⇔ George M		2. Name and Addre		emation S	ociety o	of MD, Inc. MD 21228
			23a. Part1. Enter the disease, or comp	lications that caused the	he death. Do not en					Approximate
1	Physician		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line		00				Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	aDue to (or as a	consequence of):	70				
	Examiner		Sequentially list conditions	h						
9	outed d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):					
760,√ ₹	ite be executed ysicien and ne burial-transit	cal Exa	resulting in death) Last	Due to (or as a	consequence of):					
89	ifficate g phys as the			u.						
Box	The law requires thet the death certificate tie hes been signed by the ettending physbage 2 should be detached for use as the	by Physician/Med	in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	<i>'</i>		23d. Date o Month	of delivery Day Year
P.0	set the de d by the e etached	Phy	9 Unknown						VII III	
	res ther signed to be det		Part II. Other significant conditions co	1	1.2	inderlying cause giv	en in Part I.			ute to the cause of death?
orc	w require been si should I	Completed	Myocaraia	Inta	CMON			Yes	2 □ No 3(Probably 4 Unknown
Sec.	e law hes b	nple.						24a. Was an autopsy	prio	re autopsy findings available or to completion of cause of
Vital Records,								perfond 1 ☐ Yes 2		th? Yes 2□ No
V.	Physicien: this certificated director,	@	25. Was case referred to medical examiner?	lospital: 🔪 🚜		oth Oth	or	Check only one		
of	ding Phys h. After this funeral di	. To	1 ☐ Yes 2 ☑ No 2 Z. Manner of Death	28a. Date of Injury	28b. Time o	III 3 DOA	4 Nursing Ho	me 5 Residen 28d. Describe how		(Specify)
ion	Attending F r death. octor: After by the funera	ate	Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Yeer) Injury		k? Yes 2 □No		0	
Division of	Attendi	E E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, st	reet, factory, office		28f. Location (Stre		or Rural Route Number,
Ö	rs afte ei Dir ed in	Cert		building, etc.	(Specify)			City of Town,	State)	
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	h occurred at the tin exestigation, in my o	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	ise(s) and manne e and place, and	er as stated. I due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (A	Month, Day, Year)
			brund	MO		06	1331	1	119/08	
	Q.		30. Name and address of person who co	90	m =	Print)	eris / a	R.L.	m m	D =1237
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Mino Ida	- Jille	Jaitin	DEC III	1 - 1 - 1
£	Registr	7	JAN 2 3 2008		the day	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
DH	MH 17 Rev 1/20	01	A. A. A. A. A. A. A. A. A. A. A. A. A. A	Eth - Carlot - Are	The state of the s	and with				
					ORIGI	NAL				

08-00418 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Edward Smith** 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deat Physician/ Month Day January 14, 2008 1905 hrs **Medical Examiner** Edward Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore University Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min Director 212-39-0668 1X M 2 Country) 16-1993 14 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show MD N/ABaltimore Pages I and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. Director 10g. Citizen of What Country 10e. Street and Numbe 10f. Zip Code S Α 21225 2368 Seamon Avenue Apt A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Yes 2 X No If Yes. Give Year Specify: Black Yes 2 X No specify. Widowed Divorced à 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 N/A N/A N/A 8th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joy D. Jackson Be Edward K. Smith, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is n traumatic Joy D. Jackson - Mother 1353 Spellman Road Balto, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 crematory or other place) Removal from State King Memorial Pk 1/22/2008 tant: Randallstown, Donation 5 Other Specify: 21. Signatur uneral Service Licenses March F/H East 22. Name and Address of Facility Ε. North Avenue 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medica a. Gunshot Wound of Chest Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy 1 Fetal death past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown The law requires that the 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of certificate has performed? . death? 1 🗸 Yes Yes 2 No 26 Place of Death (Check only one) 25. Was case referred to medica Be this Certification: To 27

To the Hospital or Attending Physician: Division of Vital After To the Fineral Director:

1 ✓ Yes 2 No	Inpatient 2 🗸 E	ER/Outpatient 3	DOA Suiei4 Nursir	ng Home 5 R	esidence 6 Other:
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	FOUND: Day, Year)	28b. Time of Injury FOUND: 1823 hrs	28c. Injury at Work? 1 Yes 2 ✔ No	28d. Describe ho Subject shot	w injury occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At hor (Specify) Parking Lpt			or Town, Sta	eet and Number or Rural Route Number, City te) bad, Baltimore, MD
one) 2 Medical Examiner: Or	To the best of my knowledge to the basis of examination and and manner stated.				(s) and manner as stated. nd place, and due to the cause(s)
29b. Signature and title of certifier		29	c. License number		29d. Date signed (Month, Day, Year)
aux 2			O.C.M.E.		January 15, 2008

111 Penn Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year) State Registrar

Medical 29

32. Registrar's Signature

Ana Rubio MD.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Yes 2

21202

Death

Year

2 No

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 15 Sterrett Andrew 01 Charles /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 □ F Director 88 19 216-16-3251 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Baltimore Directo MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21212 822 Wilbert Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 7th grade College (1-4or 5+) Armco Steel Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Sterrett Carrie Charms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 822 Wilbert Ave, Baltimore, Md Lowan A. Sterrett-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition United the second state
□ Burial 2 □ Cremation 3 □ Removal from State
□ Donation 5 □ Other (Specify) Garrison Forest Vet 1/28/08 Owings Mills, Md 21. Signature of Funeral Service Lice 22. Name and Address of Facility
March F/H West Baltimore, 4300 Wabash Ave, 4nmpson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician INTRA ABDOMINAL HEMORRHAGE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence off Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown DOB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2-No 962596 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be Hospital: 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death .1-Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3. Time of Death

Birthplace (State or Foreign Country)

Black

21212

21215

Day

29d. Date signed (Month, Day, Year)

2008

Approximate Interval Between Onset and Death

MD

10d. Inside City Limits

Y☐Yes 2☐No

18 150 PM

Year

2008

Hospital

Registrar

State

Medical

4 Homicide

(Check only

29b. Signature and title of certifier

PRACHI JOG

31. Date filed (Month, Day, Year)

GOOD SAMARITAN HOSPITAL BALTIMORE 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES 000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 08:40AM Smith 2008 Jan 6 David /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ₹ M 2 □ F 53 Director 218-62-0834 28 54 MD 06 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 XYes 2 ☐ No Catonsville Director Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21228 U.S.A. 311 Whitfield Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other than any injury or other traumatic event, the Beth Steel corp 9th grade na Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Day John B. Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 311 Whitfield Road, Catonsville, Md 21228 Carolyn Smith-Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State King Memorial Park 1/23/08 Randallstown, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West trune 21215 4300 Wabash Ave, Baltimore, Md hompson 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DAYS SEPTIC SHOCK /Medical Due to (or as a consequence of): Examiner ENAL DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a consequence off Examiner HEPATIC FAILURE WITH JAUNDICE use as the burial-transit Due to (or as a consequence of): aftending physician for use as the burial Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. þ CARPIOMYOPATHY 1 Yes 2 No 3 Probably 4 Unknown Completed ARTERY DISEASE CORONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 s certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this of funeral directions P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural Injury Division within 24 hours after death.

To the Funeral Cirector: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

Jarima

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

900, South caton avenue, Baltimore, MD, 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Chaturvedi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 3. Time of Death dent's Name (First, Middle, Last) Physician 11:35 PM January 17. 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death institution, give street and numbe Examiner 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 Director 1aru iana ud 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2√No Specify: Completed by 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages '
Department of H
Important: If ite
any injury or ot
once. 3 ☐Removal from State 2 Cremation 08 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licer LtO-MD aricid Approximate Interval Between Onset and Death Do not enter the mode of dring, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final metabolio andosis day **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Stroke that the death certificate be executed physician and is the burial-tran-Due to (or as a consequence of): HTN Physician/Medical as attending properties of the properties of the second secon IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes P.O. ed by the a 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by The faw requires 1 Yes 2 No 3 Probably 4 Unknown has been sig ge 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform page certificate 1□ Yes 2 No 2□ No or Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire ပ 1 Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Medical Certification: Division or Attending 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier grueny 17,2008 AT 243 8946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union memorial Hospital MD

Registrar DHMH 17 Rev 1/2001 Maurice

31. Date filed (Month, Day, Year)

Sheppard MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** HELEN ELIZABETH NOLAN TIGNALL 10:00P M 2008 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 102 D Swarthmore Drive Baltimore County Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 215-09-8447 June 7, Director 1913 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d, Inside City Limits 28a-f show iral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 No Director Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 102 D Swarthmore Drive 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 Nidowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) Nurse's Aide Medical Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Purcell Benedict Nolan Nina Mae Adams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marian Muth (Daughter) 102 D Swarthmore Drive, Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 1/19/2008 Baltimore, Maryland 21. Signat u∕3 of Funy ral Service Libra see 22. Name and Address of Facility
MITCHELL-WIEDEFELD FUNERAL HOME, INC Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the made of dying, such as cardial or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, fram, leading to infiliation cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 40 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No P 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours and over To the Funeral Director: After To the Funeral Director: After To the Funeral Director over To the Funeral D Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medica Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical (Check only one) On the basis of exa investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi c. License number

Ayman Akkad, M/D., 31. Date filed (Month, Day, Year) State 3 2008 Registrar

7600 Osler Drive, Towson, Maryland 21204 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark.

			For State Registrar	State of Maryla	-	tificate of			Reg. No.	08 01278
	[∞] Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
*.	/Medic	al	Paula Trantas	street and number		4h City Town o	r Location of Deatl		ARPAY 18,	
	Examin	er	4a. Facility Name (If not institution, give	"Medical C	enter	4b. Oity, Town, o		son	4c. County (of Death Baltimore
	Funeral Director		218-52-3306	7. Age (In yr	s. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	(Month, Da	h y, Year) 8 1948	Birthplace (State or Foreign Country) MD
	/land ow at		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Loc	ation				10d. Inside City Limits
	e Mary la-f sh tified	ctor	MD Harfor	d B	el Air					1 □Yes 2 No
	or 28 be no	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	eath v	Funeral	514 Dallam Ct.	12. Was Decedent Ever in	U.S. 13. V	21014		pecify Yes or No	USA 14. Race	- American Indian,
336	be filed within 72 hours after death with the Maryland Hyglene. Hyglene. ad other than "natural"; or Items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ½ No If Yes, Give Year or Dates:		_	lispanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)	Black Specify:	k, White, etc.
2	72 hou natura dical E	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	ent's Usual Occup	oation during most of word)	rking I	16b. Kind of Bu	
121	within ane. than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retire rsing	d)		II+414	zation Review
2		Be Co	17. Father's Name (First, Middle, Last)		Nu.	LSING	18. Mother's Nar	ne (First, Middle,		
/lan	2 should be and Mental Is marked o aumatic eve	To B	Paul Adkins				Mildre	ed Ellio	tt	
/ar/	and sund		19a, Informant's Name/Relationship (Ty	pe. Print)			and Number or Re			
بة بة	s 1 and 2 of Health item 27 I		Dana Trantas/Dau 20a. Method of Disposition	ghter 20b		Beaver (Sition (Name of patory or other pla		Baltimo:		236 City or Town, State
ē	Pages nent of int: If its iny or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		of Faith	1	22/08	Ralti	more MD
Baltimore, Maryland 21215-0036	permit. Pages Department of I Important: If ite any Injury or of once.		21. Signature of Funeral Service Licens		22	. Name and Addre		himunek	Funeral	Home Inc.
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	cations that caused the de						Approximate Interval Between
8	Physician		Immediate Cause (Final disease or condition	END STA						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
	- PN	e	Sequentially list conditions, if any, leading to immediate	Due to (or es a consi	equation of):					
۶.	scuted nd transit	Examiner	Sequentially list conditions, if any, buding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
£8,09,89	tificate be executed ig physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a cons	equence of):					
687		ledical		I						
			Zob. was decedent pregnant	3c. If yes, outcome pf preg		Ectopic pregnanc	у			e of delivery nth Day Year
o T	The law requires that the death oe the has been signed by the attendir oage 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 🗖 No 9 □ Unknown	4□Pregnant at time o 9□Unknown		Other (specify) _			Moi	nth Day Year
٠ <u>.</u>	w requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions co	ntributing to death but not r	esulting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contr	ibute to the cause of death?
rds	en sign	ed by						1 🗆 '	Yes 2 No	3 ☐ Probably 4 ☐ Unknown
Records,	a law ras be	Completed						24a. Was autor	osy p	Were autopsy findings available prior to completion of cause of
			OF Man area referred to modical				00 5) (5	1□ Yes	2 No 1	leath? ☐Yes 2 ⊠ No
· Vital	yslcfar s certii directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1 Inpatient 2	☐ ER/Outpatien	t 3□ DOA Ott	26. Place of Del ner: 4 \(\sum \) Nursing I	ath <i>(Check only c</i> Home 5 □ Resi		er (Specify)
<u></u>	ding Phi h. After thi funeral		27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe I	how injury occurr	ed
Division or	ttendli leath. tor: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of injury - At	home form etre		Yes 2 □ No	296 Location (Strot and Numb	er or Rural Route Number,
2	al or A	Certification:	4 ☐ Homicide determined	building, etc. (Spe	cify)	set, factory, onice		City or To	vn, State)	er or nurar noute Nuriber,
	To the Hospital or Attending Physician: white 24 hours after deals. To the Funeral Director: After this certification the Funeral Director. After the function of the funeral director, and the funeral director, and the funeral director.		(Check only 2 Medical Exami	sician: To the best of my k						
	To the within 2 To the Complet	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed	d (Month, Day, Year)
)	F S F O) goginder	Mehta	m.0	D4	1410		Janyary	1815,2008
	10		30. Name and address of person who co							
	(••	JOGINDER F. ME 31. Date filed (Month, Day, Year)	HTA, M.D. 32 Registrar's Sig		OSLER I	DRIVE,	TOWSON,	MARYL	AND 21204
	Sta		IAN 2 3 200		In his	AP I				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29c per dwr/ 8875 1-23-08 extra and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Rose 11:55 A M yson Jan. 15 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Maryland Medical Center Baltmore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Numbe 6. Sex **Funeral** Days Hours 1 □ M 2 F 214-62-6058 55 Director MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Merical Examiner must be notified at 1 Yes 2 No Baltimore Director MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any injury or other traumatic event, th. Me itea Examiner must be I U.S.A. 21215 5416 Wabash Ave Apt Cl Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nurse 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amy Purford Roger Richardson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5416 Wabash Ave Cl, Baltimore, Md 21215 Danny Trotman Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Md Metro Crematory Inc 1/22/08 Baltimore, 5 Other (Specify) 4 Donation 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Funeral Service Licens Signat 21215 JUL (23a. Part / Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disea e or condition resuling in death) Sepsis 3 weeks **Physician** /Medical Due to (or as a consequence of): Examiner Bacterial Peritonitis 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🔀 No 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2000 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA P 28b. Time of 28c. Injury at Work? 28a. Date of Injury 28d. Describe how injury occurred 27 Manner of Death Medical Certification: 1 Natural 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P22220 Jan 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Smith

2008

32. Registrar's Signature

The Alles

atherine

JAN 23

31. Date filed (Month, Day, Year)

22 S. Greene St., Baltimore, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of	of Marylan	-	artment of H		Mental Hyg	giene	000	n i '	280
		_1	State Registrar			Cei	rtificate of	Death		leg. No	000	Uli	200
P	։ hysicia	an.	Decedent's Name (First, Middle	, Last)					Date of Dea Month	Day	Year	3. Time	
	/Medic	al _		L. Vecch					Januar	-		8:30	_ a ™
E	xamin	er	4a. Facility Name (If not institution	, give street and nu	mber)		4b. City, Town, or	r Location of Death			ounty of Death		
			4206 Raab Ave. 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	Nottingh If Under 1 Year		8. Date of Birth	1	1timore	place (State	or Foreian
	neral ector		218-42-6285	1 X M/ 2□ F	63	Yrs.	Months Days	Hours Min.	(Month, Day April 24	, Year)	Cos	vland	a. , a. a.g.,
	w		Usual Residence of Decedent		03				Whill S	1,174	4 Mar		
yland	at at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside (
e Ma	a-t s tified	cto	Md. Baltim	ore	Nott	ingham	11						es 2∐No
if the	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Co	untry?	
ath w	ust t		4206 Raab Ave.			- I.	21236			U.S.A		iona Indian	
ar de	tems ner m	Funeral	11. Marital Status	Armed F	edent Ever in U orces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	12	 Race - Amer Black, White 		
S affe	, or l	by F	1 ☐ Never Married XX Marr 3 ☐ Widowed 4 ☐ Divorced	ried Y Yes I Yes, G Year or D	ive ≥ Z∐ No		1⊡Yes 2√XNo	Specify:		S	Specify: Wh	ite	
3 10	etcra Sal Ec	ed	15. Deceden	t's Education			dent's Usual Occup			16b. Kind	d of Business/l	ndustry	
C 13	n "ng Medic	plet	(Specify only highest Elementary/Secondary (0-12)	-	(1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor. d)	king				
d with	the I	Completed	12	Jonege		Mil1	wright			Crow	n Cork	& Sea	1
ai Hy	d other than "natural", or items 23a or 28a+ snow event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle,					18. Mother's Nam			iurname)		
aryland 21215-50036 should be filed within 72 hours after death with the Maryland and Mental Hygiene.	arked atic e	2	Samuel Vec	chioni				Mary	Glorio				
2 sho	f item 27 is marker r other traumatic e		19a. Informant's Name/Relations	hip (Type. Print)		1	ng Address (Street					(ip Code)	
and lealth	m 27 her ti	-	MaryEllen Vecch	ioni	20h I		Raab Ave.	. Notting	ham,Md.		6 ation - City or	Town State	
Baltimore, Maryland 21 Permit. Pages 1 and 2 should be filed with perfect of Health and Mental Hygier	or of		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation		State Gar	cemetery, cre dens 0	matory or other place f Faith	Jan.			imore,		
Baltim permit. Pag Department	rtant:	ì	4 □ Donation 5 □ Other (S 21. Signature of Eugeral Service				2. Name and Addre						
Balt permit. Departr	Important: i any injury o once,		21. Signature of Furteral Service	100				-	TI T	970.	5 Belai	r Rd.	206
100			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deal	th. Do not en	chimunek ter the mode of dyi	runerar ng, such as cardiad	or respiratory ar	rest,	timore	Approxim	nate
Division			shock, or heart failure. List Immediate Cause (Final			\	Trace ?.	21)				Interval B Onset an	d Death
	ician dical		disease or condition resulting in death)		(or as a consec		UTARCATI						
Exar	miner				(0	,							
	HOH	Je.	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	or as a conse	uence of):							
18 B	nd ransit	Examiner	that initiated events	с									
0 , 7	sician and burial-transit	Ä	resulting in death) Last	Due to	o (or as a consec	quence of):							
Records, P.O. Box 68760, %	hysic the bi	dical		d									
ertije O	ling p	Med	IF FEMALE:	OGO If you o	utcome of progn	anav							
Box eath cer	attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome pf pregn birth 2 Fet	al death 3	□Ectopic pregnanc □ Other (specify) _	у		23	3d. Date of del Month	Day	Year
. કું .	the s	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk	nant at time of one of the second of the sec	ueam 51	Other (specify) _						
P.O.	signed by the a l be detached f		Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	obacco us	e contribute to	the cause o	of death?
Vital Records, sician: The law requires the	sign Id be	d by							1 🗆 `	res 2	No 3□Pi	obably 4 [□Unknown
V req	speen sig	Completed							24a. Was	an	24b. Were au	utopsy finding	gs available
Fe a		dmo								rmed?	prior to death? 1 □ Yes	completion o	f cause of
<u>a</u> : _	tificat or, pa		25. Was case referred to medica	ıl			- Carrier	26. Place of Dea	1 Yes ath (Check only o	2 No	I L Tes	2200	
ysick	his certificate has I director, page 2	To Be	examiner? 1 ☐ Yes 25 No	Hospital: 1	Inpatient 2]ER/Outpatie	nt 3 DOA Oth	ner: 4 🗆 Nursing H	lome 5 Resid	dence 6	□Other (Spe	cify)	
O 4	ter th	<u> </u>	27. Manner of Death	(8.40	e of Injury onth, Day Year)	28b. Time of Injury	of 28c. Inju Wo	ry at	28d. Describe I	now injury	occurred		
ath.	or: Af	atio	1 Anatural 5 ☐ Pendir investi	gation				Yes 2 No					
Division or lor Attending Phys after death.	Director: After in by the funer	Certification:	3 ☐ Sulcide 6 ☐ Could 4 ☐ Homicide determ	sinod Zoe. Flat	ce of injury - At h ding, etc. <i>(Sp</i> ec	iome, farm, st ify)	reet, factory, office		28f. Location (3 City or Tox	Street and vn, State)	Number or R	ural Route N	umber,
ital o	rai D								<u> </u>	- (-)			
Division or Vital To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After th completely filled in by the funeral	Medical		ng Physician: To the I Examiner: On the									e(s)
o the	To the comple	Mec	29b. Signature and tille of certific		inter stated.		29c. Licens	se number		29d. Date	signe# (Mon	th, Day, Year	r)
F '≩	μŏ		16.00	MM -			059	7359		110	20/2		
	- 0		30. Name and address of person	who completed car	use of death (Ite	m 23a) (Type	, Print)		Į.				
-	20		4924 Gar	obell Blu	D SUTTE	H30	> Bottom	ore, MC	21236	2			
.*	Sta	ate	31. Date filed (Month, Day, Year,	2000 32	Registrar's Sign	nature	colles .						
	Regist	rar	JAN 23	2008	Sistem of	of the same							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 17, 2008 5:50 Wallace W. Whetsell January am /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County 2600 Pearwood Road Parkville if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 12/25/1924 West Virginia Director 83 234-32-8087 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 ☑No Maryland Baltimore County Parkville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 United States 2600 Pearwood Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Tes, Give Year or Dates: 1943–1946 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 25√2 No Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event. the 9 Asst. Superintendent Country Club 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Helen Whetsell ပ George Henry Whetsell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2600 Pearwood Road Parkville, Maryland 21234
ce of Disposition (Name of Date 20c. Location - City or Town, State Betty D. Whetsell/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/21/2008 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, Inc. Bean a Will 9705 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician iver 4 mon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 No 1□ Yes 2 NO director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. this 28a. Date of Injury 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Jan 18 2008

31. Date filed (Month, Day, Year) State Registrar

30. Name and address of person who haves ladgett, mis 5601 Loch Ravey Blul, Baltimore, MD 21239 32. Registrar's Signature

2008

mpleted cause of death (Item 23a) (Type, Print)

			For	State of Maryla	•			Mental Hy		0.8	01292
			State Registrar 1. Decedent's Name (First, Middle, L.)	acti	Cei	rtificate of I	Death	2. Date of De	neg. No.L.	0.0	3. Time of Death
Phys	sicia: edica		SUNG SOOK	AHN					7 3, 2008	3 ^{Year}	7:45 PM
	mine	_	4a. Facility Name (If not institution, g				Location of Death	n	4c. County		
			Shady Grove Adve		s. last birthday)	Rockvi	LLe If Under 24 Hrs.	8. Date of Bir	Mont		y lace (State or Foreign
Funer Direct			242-27-2238	1□M 2X F 84		Months Days	Hours Min.	Aug. 1	9,1923	Count Ko1	try) rea
pu »		- 1-	Usual Residence of Decedent	100 (City, Town or Lo	postion				10	0d. Inside City Limits
faryla f shov ed at			10a. State 10b. County MD Montgo		Saithers					"	1 X Yes 2 No
the Nr. 28a-		Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
th with 23a o ast be	3	<u>a</u>	444 North Summi	t Ave. #203		208	77		United S	State	s
idryiand ZIZI3-UU30 2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. I marked other than "natural"; or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		בֿ	11. Marital Status 1 ☐ Never Married 2 X Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2፟X No	Ispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	Blac	k, White,	etc.
5-UU50 72 hours at natural", or lical Exam	3	o b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:						Asi	
in 72 n "nat		Сошріете	15. Decedent's (Specify only highest g	rade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor i)	rking	16b. Kind of Bu	siness/inu	ustry
d with giene giene		<u> </u>	Elementary/Secondary (0-12)	College (1-4or 5+)	Home	emaker			Own Ho	ome	
be file ntal Hy ad othe	3	a	17. Father's Name (First, Middle, La: Tae Keun Kim	st)			18. Mother's Nar Shin Du		, Maiden Surnam	e)	
should Me mark	15	2	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street			per, City or Town,	State, Zip	Code)
mod 2 sauth au 27 is er trau			Hae R. Pak (Dau	ghter)	226 0	Grange Ha	11 Dr. G	aithersl	ourg, MD	2087	7
DEMILITIONE, MISTYISTIC ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatilth and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	,		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State	cemetery, crei	osition (Name of matory or other place Iemorial		Date 08	01ney,		wn, State
Dermit. Departn Imports any Inju	ouce.		21. Signature of Funeral Service Lic	ensee Au		2. Name and Addre					D 20877
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the de- ly one cause on each line.		_					Approximate Interval Between Onset and Death
Physicia	-		Immediate Cause (Final disease or condition resulting in death)	a dive	y Ci	xx40	sts				Oliset and Death
/Medic Examin	200		Tooding in dodain	Due to (or as a conse	equence of):	syto Suce	101	actt	0		
		2	Se uentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):		- Gay o	pana	3		
ecutec and transi	1	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Ken	ar	Jent.	Me				
o rou, sate be executed physician and the burial-transit				Due to (or as a conse	equence oi).						
oo/ tifficate g phys as the	3	edical		d							
I necolus, F.O. box 06/00, The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	100	riiysiciaii/iwe	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf preg 1 ☐ Live birth 2 ☐ Fe		∃Ectopic pregnancy	,			te of delive	ery Day Year
he dea the at	1	ysic	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4□Pregnant at time of 9□Unknown	f death 5	Other (specify)			IVIO	11011	Day Teal
that the hed by detact	ď		Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use cont	ribute to th	ne cause of death?
v requires been sign should be	1 2	an nà						10	Yes 2 No	3 ☐ Prob	pably 4 ☐Unknown
law re as being be	1 2	najaiduion						24a. Was	psy	prior to cor	psy findings available mpletion of cause of
ian: The ratificate h								perf 1□ Yes		death? 1 ☐ Yes	2 No
VII. siciar certif	9	ם כ	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	er:		o <i>ne)</i> sidence 6 ⊟Oth	or (Capait	5.1
g Phy g Phy ter this neral d	F	- 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how injury occur	. , .	y)
Attending r death. ector: Afte by the fune	15	gano	1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	on		M 1□	Yes 2 □ No				
or Att	9	Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			reet, factory, office			(Street and Numb own, State)	er or Rura	il Route Number,
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	100	enical C		Physician: To the best of my ki aminer: On the basis of examinand manner stated.							
To the within To the comple	M		29b. Signature and title of certifier		/	29c. Licens			29d. Date signe		
3			1 () 5	m/ &		D	1362	-/	Janya	14	4, 2008
			30. Name and address of person wh	o completed cause of death (Ite	em 23a) (Type,	Print)	124 4	as and	Janua Josha	1	1. 1
	State	2	31. Date filed (Month, Day, Year)	32 degistrar's Sig	mature I	J4 gely	Nosch.	ect.	Killix	4317L	19 10x19
	istra	-	JAN 07 2	008 Dece	it do	Sect.					5/

DHMH 17 Rev 1/2001

an al er	1 - State Amend #18, 1 1 - State Amend #18, 1 1 Decedent's Name (First, Middle, L Helen M. Alag							Reg. No.		
ai	Helen M. Alas						2. Date of D		_ U U U	3. Time of Death
	, , ,	cio					Month	O 7		3 2258 M
	4a. Facility Name (If not institution, g.					ocation of Deat	th		County of Dea	
	Howard Count					Inbia If Under 24 Hrs	10.00		lowar	
	218 26 2293	94ex 7.7 1 □ M 2 🖾 F	Age (In yrs. las f birthe 76 Yr	Months		Hours Min		ay, Year)	C	thplace (State or Foreigountry) aryland
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town of	r Location						10d. Inside City Limit
ō	MD Herman	3	TIL: co	~:						1 □ Yes 2 N
Director	MD Howard 10e. Street and Number	۱	FITTO	tt City	Code			10g. Citiz	zen of What C	ountry?
Ö	8720 Ridge Road	Apt. 105		210)43			Un:	ited St	ates
ner	11. Marital Status	12. Was Deceder		13. Was Decede	nt of Hisp	panic Origin? (S	Specify Yes or N		14. Race - Ame	erican Indian,
	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 27					nto mican, etc.)		C-neif	
d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates							WI	nite
lete	15. Decedent's l (Specify only highest g	Education rade completed)	16a. D	ecedent's Usual Give kind of work	Occupati done dui	ion ring most of wo	orking	16b. Kir	nd of Business	/Industry
ф	Elementary/Secondary (0-12)	College (1-4o	r5+)					Hote	ale s C	'onstructio
		st)	<u> </u>	ii Giarç						OHSCH GCCLO
OB	Bernard R. Wess	, Sr.			M	Marie E	lizabeth	Car	oovitek	* Karpovitc
-	19a. Informant's Name/Relationship	(Type. Print)	19b. N	failing Address (8						<u>+</u>
11 9	Vincent A. Alasc	io Sr./Hus	sband 87	20 Ridae	e Rd.	Apt 1	05 Ellic	ott (City. N	nD 21043
1	20a. Method of Disposition		20b. Place of D	isposition (Name crematory or oth	of er place))	Date			
			e			1	1-2008	Syke	esville	e, MD
1	21. Signature of Funeral Service Lic	ensee 11	M01044							
07	Som belles	- With								
	23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications that caus y one cause on each	ed the death. Do not line.	enter the mode	of dying,	such as cardia	c or respiratory	arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition	a Sei	otic she	ock						Onset and Death
	resulting in death)					_				
_	Sequentially list conditions,	b	rratic	Pact	ve	mia				olnys
nine	cause. Enter Underlying Cause (Disease or injury	(or a scale and	(/	hole	الم مرم م	£1/e			days
Exar	that initiated events resulting in death) Last	Due to (or a	as a consequence of)	:		7211	117			2(2)9)
		d								
ledi										
an/	23b. Was decedent pregnant			3 □Ectopic pred	nnancv			2		
sici	1 ☐ Yes 2 ☐ No	4□Pregnant	at time of death						Month	Day Year
Phy				o nodentides -		in Dard I	00- 011	tobass	no contails a	to the power of to the
ρ				ie undenying cau	ise given	in Parti.		/		o the cause of death? Probably 4 □Unknow
sted	M. 1. (151 a.	"11 -1".)) 🛶 , 🖰							
nple							auto	psv	prior to	utopsy findings availab completion of cause of
S	Chronic Ob	structiv	e Pulmo	nary 1	rise	ease	1□ Yes	2 No	1 ☐ Ye	s 2□No
Be	examiner?	Hospital:		/	Othor					
	The state of the s	1 Linpa			1	Indianig				ecify)
ig	1 Natural 5 ☐ Pending	(Month, E	<i>Day Year)</i> Inju				200. 2000/120	now anjung	, 00001100	
fica	3 Suicide 6 Could not		njury - At home, farm	, street, factory,	office	_				lural Route Number,
erti	4 Homicide	building,	etc. (Specify)				City or To	wn, State	,	
	29a. Certifier 1 Certifying F (Check only 2 Medical Ex	Physician: To the besaminer: On the basis	st of my knowledge, of examination and/	leath occurred at	t the time	e, date and place	e, and due to the	e cause(s)	and manner a	is stated.
ledi	one)						- I			
-	29b. Signature and title of certifier		1					29d. Date	signed (Mon	tn, ∪ay, Year)
	Mund	an M	D					Jan	08	2008
			death (item 23a) (Ty	rpe, Print)	4 0	+ 0-1		ale	10.5	MDair
	31 Date filed (Month Day Year)		trar's Signature	, = 1014	'N PM	1 FOVE	way C	Ulun	11/101	111 2104
	e Completed by Physician/Medical Examiner To Be Completed by Funeral	ST20 Ridge Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest go 15. December go 15. December go 15. December go 15. December go 15. December go 15. December go 15. December go 15. December go 15. December go 15. December go 15	1. Marital Status	Reference Road Apt. 10 Reference 10 Re	State Stat	1 Serial 1	100 100	1980 100	11 Mailing Address (Street and Number of Plant Route, Market) 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin' (Specity Yes or No. 11 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin' (Specity Yes or No. 11 16 Was Decedent of Hispanic Origin' (Specity Yes or No. 11 16 Was Decedent of Hispanic Origin' (Specity Yes or No. 11 16 Was Decedent of Hispanic Origin' (Specity Yes or No. 11 16 Was Decedent of Hispanic Origin' (Specity Yes or No. 11 16 Was Decedent's Education (Specify or Work kerry during most of working (Specify West or No. 11 16 Was Decedent's Usual Occupation (Specify or Work kerry during most of working (Specify West or No. 11 16 Was Decedent's Usual Occupation (No. 11 16 Was Deceden	18 #20 Ridge Road Apt. 105 11 Maria Status 11 Maria Status 11 Maria Status 12 Was Decedent of Repair Origin? (Specify Yes or No-Maria Coloration of Colorat

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ASTATE OF Maryland F Besamment of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day January 17, 2008 **Physician** Kathleen Marie Brown 11:33 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Solomons Nursing Center Calvert Solomons | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 5, 1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 474-34-5764 72 Director Minnesota Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Fort Washington Maryland Prince George's Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20744 3103 Lumar Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Race - American Indian Black. White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 White Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice Kresky Allen McDonell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5510 Chesapeake Ave., St. Leonard, MD 20685 Kevin R. Brown / Son 20b. Place of Disposition (Name of Trinity Memorial 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2008 Gardens Waldorf, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEMONIA ASPIRATION **Physician** /Medical flue to (or as a consequence of): Examiner FAILURE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed ALZHEIMERS Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PSYCHOSE. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Surring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient ဂ္ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident within 24 hours at er death.

To the Funeral Director: A completely filled by the fu death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JANUARY 18, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gwyneth Blattan, NO 110 Hospitalkot #30 Prince Frederick NW 20678

State Registrar

31. Date filled (Month, Day, Year)

JAN 23

0

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 17, 2008 Year JAN. 8:17 AM MARJORIE LOIS BRADBURN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death CHARLES INDIAN HEAD 5695 PORT TOBACCO ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number Months Days Hours Min. 1 🗌 M 3-5-1937 577-50-8211 70 WASH., D.C. Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No INDIAN HEAD MD. CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20640 5695 PORT TOBACCO ROAD 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify: Specify: WHITE 3 → Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HARRIETT HAGAR RICHARD BURNS LANHAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) IRVING PLACE INDIAN HEAD, MD. 20640 DARRYL BRADBURN-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 1-22-08 WALDORF, MD. TRINITY MEM.GARDENS 4 ☐ Donation 5 ☐ Other (Specify) M00479 2. Name and Address of Facility 21. Signature of Juneral Service Licensee RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. ter the mode of dying, such as cardiac or respiratory arrest, HRUNI Immediate Cause (Final BICUME disease or condition resulting in death) s a consequence of MENOSCI ENVISTS IN CED s a consequence of): s a consequence of) e pf pregnancy 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown

Physician /Medi Exami

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

P

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

Division or Vital Records, P.O. Box 68760分

Examiner				HOVO
be executed slcian and burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	Due to (or as
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♥ No 9 □ Unknown Part II. Other significant conditions		c. If yes, outcom 1 ∐Live birth 4 ☐ Pregnant 9 ☐ Unknown ributing to death
To the Hospital or Attending Physician: The law re within 24 hours after death. To the Funeral Director After this certificate has bee completely filled in by the funeral director, page 2 sho	To Be Complet	25. Was case referred to medical examiner? 1 □ Yes 2 1 No	Но	ospital: 1
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	be	28a. Date of In (Month, D
To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	dical Cert	29a. Certifier Certifying F (Check only one)		clan: To the bes
To th withir To th comp	Me	29b. Signature and title of certifier	1	116

							24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autoprior to condeath?	opsy findings available ompletion of cause of 2 No
				26.	Place of Dea	ith (C	Check only one)		
	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient	3 🗆 D(OA Other: 4	☐ Nursing H	lome	5 Residence 6	□Other (Speci	ify)
ition	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2□No	280	d. Describe how injury	occurred	
ot be ied	28e. Place of injury - At ho	me, farm, stree	t, factor	y, office		28f	Location (Street and City or Town, State)	Number or Rui	al Route Number,

st of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) stated.

completed cause of death (Item 23a) (Type, Print) Name and address of pers

08 ALDURY- MUl. 20603

State Registrar FRO REID WeN. 32 Registrar's Signature

MD

Baltimore, Maryland 21215-0036

		State of Maryland / Del	partment of H ertificate of L		ntal Hygie Reg.	0000 01000
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Kimberly Dawn Baugher			Date of Death Month anuary	Day Year 5 2008 8:22 P M
Examine		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital	4b. City, Town, or Freder	ick		4c. County of Death Frederick
Funeral Director		5. Social Security Number 218-82-1386 Usual Residence of Decedent 6. Sex 1 M 2 K 7. Age (In yrs. last birthde	Months Davs	If Under 24 Hrs. 8. Hours Min. No	Date of Birth (Month, Day, You V 26, 1	ear) 1963 9. Birthplace (State or Foreign Country) Mary J and
Maryland a-f show iffied at	ctor	10a. State 10b. County 10c. City, Town or MD Frederick Frederic				10d. Inside City Limits 1 Yes No
tth with the 23a or 28 ust be not	ral Director	10e. Street and Number 4891 White Spruce Lane	10f. Zip Code 21703		10g US	
Irs a	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:	 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No 	spanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ithin 72 hou nan "natura s Medical E	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupa ive kind of work done of e. DO NOT use retired	lurina most of workina		bb. Kind of Business/Industry
filed w Hygier Other tf	Be Cor	12 Home:	maker	18. Mother's Name (Fi		wn Home uiden Surname)
Menta Menta arked artic ev	To B	Richard John Baugher, Sr.		Sandra Jean		
id 2 sho Ith and 27 Is ma trauma		1 1 2 2	•			City or Town, State, Zip Code) Wn • MD 21740
ages 1 and of Heal		20a. Method of Disposition 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	sposition (Name of crematory or other place			oc. Location - City or Town, State
permit. Pa Departmer Important: any Injury once.			ake Cremato 22. Name and Addres			eltsville, MD e P.O. Box 784
be lois	ical Examiner	23a. Part1. Enter the sease, or complications that caused the death. Do not shock, or heart filure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ncelpha	A / A	 	Interval Between Onset and Death Flw days
To the Hospital or Attending Physician: The law requires that the death certificate it within 24 hours after death. within 24 hours after death. completely filled by the funeral director, page 2 should be detached for use as the Londen and the funeral director.	Physician/Medic		3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delivery Month Day Year
quires that the de	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause give			cco use contribute to the cause of death? 2 ☐ No 3聚Probably 4 ☐ Unknown
sician: The law requir certificate has been si irector, page 2 should I	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? I □ Yes 2 □ No
ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner? Hospital:	tiont 2000 Othe	26. Place of Death (C		
nding Phys th. : After this funeral dii	tion: To	1 ☐ Yes 2 ☐ No	ne of 28c. Injury	4 ☐ Nursing Home		ce 6 □Other (Specify) rinjury occurred
al or Atter s after dea al Director ed in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f.	Location (Stre City or Town,	et and Number or Rural Route Number, State)
To the Hospital or Attending Phyinin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, do not be as it of the basis of examination and/of and manner stated.	or investigation, in my o	pinion, death occurred	at the time, dat	te and place, and due to the cause(s)
O D William	2	29b. Signature and title of certifier Patine Pandey, M.D.		064911	1	d. Date signed (Month, Day, Year) 01-06-2008
(A)		30. Name and address of person who completed cause of death (Item 23a) (Type PRATIMA PANDEY 400 W. 7th		derick, MD	21701	
Sta Registra		PRATIMA PANDEY 400 W. 7th 31. Date filed (Month, Day, Year) JAN 0 8 2008 JAN 0 8 2008	board .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:45P M William Marvin Brooks, Sr. Januarv 15 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 1 XM 2 ☐ F Months Days Hours 4 1935 213-26-4867 Jan. Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No MD Calvert North Beach 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3838 8th Street 20714 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 【XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 X Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Superintendent construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ray Rufus Brooks Myrtle Lee Sturdivant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Denise L. Brooks, daughter PO Box 24, Accokeek, MD 20607 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Harmony Cemetery 01-19-2008 Owings, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PROSTATE Immediate Cause (Final DECINON disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TERM 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ner 24a. Was an autopsy tral performed?

Physician /Medical Examiner

as

funeral director

Director

within 24 hours at To the Funeral D Hospital

or Attending

Physician

/Medical

Examiner

Directo

Funeral

2

Completed

Be

မ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

and Mental Hygiene.

permit. Pages 1 and 2 st
Department of Health and
Important: If item 27 is n
any Injury or other traun
once.

death

filed within 72 hours after

should be

Saltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

physician and s the burial-transit Physician/Medical þ Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 | Yes 2 | No 27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ EF/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier

25435

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1000

110 Hospital Road, Suite 305, Prince Frederick, MD 20678
32. Begistrar's Signature Mukesh Mathur, M.D. 31. Date filed (Month, Day, Year)

State

Medical

Registrar

DHMH 17 Rev 1/2001

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Mar State Registrar	yland / Depa <i>Cer</i>	rtment of H tificate of L			ene 1. No. 20	08	01288
	Physicia		1. Decedent's Name (First, Middle, Last) Vada Rebecca	Bussard		ļ	2. Date of Death Month	Day 15	Year	3. Time of Death 7 20 pM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	Jussalu	4b. City, Town, or	Location of Death	January	4c. County		
		.*	Fahrney Keedy Home 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Boonsbo	OYO	8. Date of Birth	Wash	ningt	on ace (State or Foreign
	Funeral Director		213-24-9506 1□M 2\\ F	90 Yrs.	Months Days	Hours Min.	(Month, Day, Y Sept.13,	1917	Count Mary	ry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	Ioc. City, Town or Loc	cation				10	d. Inside City Limits
	e Man Sa-f sh tiffed	Director	Maryland Washington	Boonsbo						1 □Yes 2 □No
	with th	Dire	10e. Street and Number 2 Blue Ridge Drive		10f. Zip Code 21713		100	g. Citizen of W	/hat Count SA	ry?
	death	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13. V		spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	e - America k, White, e	
020	72 hours after death with the Maryland natural", or items 23a or 28a-f show iteal Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	1	Yes 2 No	Specify:	Thous, oto.)	Specify		
- - - -	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done of	ation furing most of work!)	ng 16	6b. Kind of Bu	siness/Ind	ustry
7 7	s within giene. r than the Me	dmo	Elementary/Secondary (0-12) College (1-4or 5+)) _	stress	,		Sewing	Facto	ory
aua '	be filec tal Hyg d othe event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Surnam Lickens	·	
Z	hould d Men marke	ဥ	Roy Wade Grossnickle 19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	a Address (Street a	Maudie and Number or Rura				Code)
Z Z	and 2 s alth an 1 27 is er trau		JoAnn Cofelice / daughter			enue, Ba				
Hore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hytiene. Inmportant: If tiem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation _ 5 □ Other (Specify)	20b. Place of Disposer cemetery, crent Grossnick	natory or other plac	e)		oc.Location - yersvi	-	
Бапттог	permit. Departm Importa any inju		21. Signatur of Fulleral Septice Licensee		Name and Addres	s of Facility uneral Ho		Main S sville		
i, -	4.3		23a. Part1. Enter the disease, or complications that caused the shock, or near failure. List only one cause on each line	ne death. Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory arres	st,		Approximate Interval Between Onset and Death
	Physician /		Immediate Cause (Final disease or condition resulting in death)	revolu (andiou	scalar	duen	0		Zo y
	Examiner		Lut 10 (or as a	consequence of):	Heart	Faller			ì	100
	pi ji	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):						1
٦, ٦	certificate be executed rding physician and use as the burial-transit	Examiner	resulting in death) Last C. Due to (or as a	consequence of):						
08/00	ate be hysicia the bur	edical	d						\rightarrow	
POX P	certific nding p		IF FEMALE: 23c. If yes, outcome p	f pregnancy	-			23d. Dat	te of delive	rv
-	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown		Ectopic pregnancy Other (specify)			Мо	nth	Day Year
ς, Τ	requires that the een signed by the	by Ph	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause give	en in Part I.				e cause of death?
coras,	v requir	eted					1 ☐ Yes	1		ably 4 Qunknown osy findings available
Ÿ	sician: The law certificate has b irector, page 2 sh	Completed					autopsy perform	ed3	prior to cor death? 1 ☐ Yes	npletion of cause of
VITA	ician: sertifica setor, p	Be C	25. Was case referred to medical examiner?		Oth		n (Check only one			
0	Physi er this c eral dir	To	27. Manner of Death 28a. Date of Injury	t 2 ☐ ER/Outpatien 28b. Time of		41 Wursing Ho	me 5 ☐ Resider 28d. Describe hov)
ion	ending ath. or: Afte he fune	atior	1 Natural 5 Pending (Month, Day 2 Accident investigation	Year) Injury		K? Yes 2□No				
UIVISION	or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,		er or Rura	l Route Number,
_	To the Hospital or Attending Physician: Within 24 hours after death To the Funeral Director; After this certification that the funeral director, sompletely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and/or in	h occurred at the tir vestigation, in my o	I ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and mate and place,	anner as st and due to	ated. the cause(s)
	To the within :	Med	29b. Signature and title of certifier		29c. Licens			d. Date signe	,	
1) mec		100	2327		01-1	6- 2	8008
	3		30. Name and address of person who completed sause of dea Khalid Waseem, M.D.; 112			rstown M	arvland	21740		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar	's Signature	mage	LUCUWII, M	стутани	<u> </u>		
	Registr	ar	JAN & J LUUO	and the same	***					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medica Examine

1 - For State Registrar

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

Division or Vital Records, P.O. Box 68760,

icia		Robert D. Bro	wn, Jr.							Month	Day	1	Year	O. Timo of	рМ
dica	-	4a. Facility Name (If not institution,		mher)		4h City	Town, or	Location	of Death	Janua	ry 3	County	008 of Death	9:21	P -
nine	er			iliber)		,									
2 173 .		Holy Cross Hosp 5. Social Security Number 6	ital Sex	7. Age (In yrs.	last birthday)			Spri:		8. Date of Bi	rth	ontg	omer 9. Birth	lace (State o	r Foreign
al or			1 M 2□F		Yrs.	Months	Days	Hours	Min.	Nov. 2		1	Cour	#ry) t Vira	inia
"	-	214-12-7712 Usual Residence of Decedent		8	6			1	<u> </u>	NOV. Z	0, 1	921	WES	CVIIG	IIIIa
		10a. State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside Cit	ty Limits
	٥,	Maryland	Montgom	orv	Po	ckvi1	1.0							1 □Yes	2 ₽ No
	<u>Ω</u> ⊢	10e. Street and Number	Horregoni	CLY		10f. Zip					10g. Cit	izen of V	Vhat Cour	ntry?	
		4932 Melinda	Court				2	0853			TT	SA			
	Completed by Funeral	11. Marital Status		edent Ever in U.	.S. 13.	Was Dece			igin? (Sp	ecify Yes or No Rican, etc.)		14. Race		an indian,	
	틸	1 □ Never Married 2 □ Married	Armed Fo							Rican, etc.)		Blac	k, White,	etc.	
	ò	3√√Widowed 4 □ Divorced	If Yes, Gi Year or D	ve		1 ☐ Yes	2¥No	Specify:				Specify	· Wh	ite	
1	eq	15. Decedent's	Education		16a. Dece	dent's Usua					16b. K	ind of Bu	usiness/In		
1	et .	(Specify only highest	grade completed)		(Give	kind of wo DO NOT us	rk done se retired	during mos d)	st of work	ring					
	Ē	Elementary/Secondary (0-12)	College (1-40r 5+)	Ac	count	ant				Fin	anci	al M	anagem	ent
	Ö	17. Father's Name (First, Middle, La	ast)					18. Moth	er's Nam	e (First, Middle				3	
	Be	Robert D. Brow	wn					Milda	red I	Elizabe	th K	este	r		
	ဠ	19a. Informant's Name/Relationship	(Type Print)		19b. Mailir	na Address	(Street			ral Route Numi				Code)	
		Barbara Wallick		r		•				Martins					
4	-	20a. Method of Disposition			Place of Dispo			- :		Date				own, State	
		1 ☑ Burial 2 ☐ Cremation 3		State	cemetery, cre	-	-	i i	Jar	•			,		
		4 □ Donation 5 □ Other (Spe		Ga	te of 1				- 2	2008	Silv	er S	prin	g, Mar	yland
ouce.		21. Signature of Funeral Service Li	censee	2.	F	^{2. Name ar} ranci	s J.	Co1	lins	Funera	1 Ho	me I	nc.		
ō		Luchen) \	ce	5	00 Un	iver	sity	Blvc	a. W. S	ilve			, MD_2	0901 -
8		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omblications that nly one cause on	caused the deat each line.	h. Do not en	ter the mod	de of dyi	ng, such as	s cardiac	or respiratory	arrest,			Approximat Interval Bet Onset and I	ween
n		Immediate Cause (Final disease or condition	Car	tio Cha	mle .									Onserand	Deali
al		resulting in death)		(or as a conseq											
er			bBla	dder Car	ngar										
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a conseq											
	直	Cause (Disease or injury that initiated events	o Obs	tructive	e Uron	at hv									
	Examiner	resulting in death) Last	Due to	(or as a conseq	uence of):							-			
	g		d												
	ician/Medical			-					-						
4	⋛│	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome pf pregn	ancy	¬						23d. Da	te of deliv		
	cial	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2□Feta nant at time of c		⊒Ectopic p ⊒ Other <i>(</i> s)						Mo	onth	Day	Year
	Physi	9 Unknown	9□Unki	nown											
	P	Part II. Other significant condition	s contributing to	death but not res	sulting in the u	underlying o	cause giv	en in Part	l.	23e. Did	tobacco	use cont	tribute to	the cause of	death?
	db	Hypovolemia, Ata	rial Fib	rillatio	on, Coi	ngest	ive	Heart	Fail	ure 1□	Yes 2	. □ No	3 ☐ Pro	bably 🛠 🕱	Unknown
	etec									24a. Wa		246	More aut	opsy findings	available
	npt									aut	opsy formed?	l l	prior to co	ompletion of c	ause of
	Completed by									1□ Yes			1 ☐ Yes	2□ No	
	Be	25. Was case referred to medical examiner?	Hoopital:				O#	205:		th (Check only					
	2	1 ☐ Yes 2x No			ER/Outpatie		UA		lursing H	ome 5□Re				ify)	
		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time of Injury		28c. Inju Wo			28d. Describe	e how inju	ry occur	rred		
	atic	2 ☐ Accident investiga	ation			М		Yes 2	No						
	iii	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flac	e of injury - At h ding, etc. (Speci	iome, farm, st ify)	treet, factor	y, office			28f. Location City or T	(Street a own, Stat		ber or Rui	ral Route Nur	nber,
	Ser														
	ja	29a. Certifier 12 Certifying	Physician: To the	ne best of my kno	owledge, dea	th occurred	at the t	ime, date a	and place	, and due to th	ne cause(s	s) and m	anner as	stated.	s)
	Medical Certification:	one)		nner stated.							1				
	Σ	29b. Signature and title of certifier				29		se number			29d. Da	_		, Day, Year)	
		Kehan	19/11	ang			D608	26				Janu	ary 4	, 2008	
	ŀ	30. Name and address of person w	no completed cau	use of greath (Ite	m 23a) (Type	, Print)									
			7801 Holli				d, MD	20855							
Sta	te	31. Date filed (Month, Day, Year)	32	egistrar's Sign	ature	1 15	•								
istr		JAN 07	2008	Hegistrar's Sign	IS A	NO SECTION									
		-													

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes of Open

			1-	For State Registrar	Otate of t	viai yiai			ate of l	Death	u IVIC	_	Reg. No.	Z U U	8	Ula	190
	4	A.	1. [Decedent's Name (First, Midd	lle, Last)						2	. Date of De	ath			3. Time of	Death
и	Physici /Medic			Boris Bechuts	skiy						J	Month	Day 02		ear 008	2315	M
8	Examir		4a.	Facility Name (If not institution	on, give street and numb	er)		4b. Ci	ty, Town, or	r Location of D	eath		4c.	County of I	Death		
1				Shady Grove Adve	entist Hospita	1			Roo	ckville				Mont	gome	ry	
6 3	Funeral		5. 8	Social Security Number		Age (In yrs.	last birthday,	If Und	der 1 Year Is Days		Hrs. 8	. Date of Birt (Month, Da	th v. Year)	9.	Birthp	lace (State o.	r Foreign
	Director			214-37-0320	1⊠M 2□F	89	Yrs.					pril 10		L8		aine	
	pu >		-	ual Residence of Decedent a. State 10b. County		10c Cit	ty, Town or L	ocation								Dd. Inside Cit	tu Limito
	larylan show ed at	-	100	i. State 100. County	y	100.01	ty, TOWITOLE	JCallOIT							'	1 ☐ Yes	
	8a-f	Director	_		tgomery					ckville							
	or 2	i	106	e. Street and Number				10f.	Zip Code				10g. Citi	zen of Wha		iry?	
	ath v s 23a rust	Funeral			Buren Street	. =				20850				U.S		an Indian	
	er de item:	E S	11.	Marital Status	12. Was Decede	es?	.S. 13.	If Yes, s	cedent of H pecify Cuba	ispanic Origin an, Mexican, P	? (Specii verto Ri	y Yes or No- can, etc.)	-	14. Race - A Black, \			
36	s aft	by F		1 Never Married 2 Mai 3 X Widowed 4 Divorced	If Yes. Give			1 ☐ Yes	2 ⊠ No	Specify:				Specify:		T.W. * .	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ther, the M-dical Ex-miner must be notified at	ba	<u> </u>		nt's Education		16a. Dece	dent's U	sual Occup	ation			16b. Ki	nd of Busin	ess/Inc	White	
15	in 72 "n" r	Completed	L	(Specify only highe	est grade completed)		(Give	kind of DO NOT	work done o	during most of	working		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		17.	,	
12	within iene.	E	3	Elementary/Secondary (0-12)	College (1-4	or 5+)		Mecha	nical I	Engineer				Engin	eeri	ng	
	Hyg other ent,	BeC	17.	Father's Name (First, Middle			1			18. Mother's	Name (I	First, Middle,	Maiden	Surname)			
Maryland	2 should be filed and Mental Hygi Is marked other aumatic event, ti	To B		Benjamin Be	echutskiv					Sara	ah S1	ipak					
37	should ind Men marke	_	19	a. Informant's Name/Relation			19b. Maili	ng Addre	ess (Street	and Number o			er, City o	r Town, Sta	te, Zip	Code)	
	1 and 2 Health a tem 27 is			Alex Bechutskiy	- Son		19	015 F	estiva:	1 Drive.	Boyd	s. Mary	land	20841			
ē,	of He		208	a. Method of Disposition			Place of Disponentery, cre	osition (f	lame of	e)	Dat	е	20c. Lo	cation - Cit	y or To	wn, State	
E	Pages nent of H			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (ate Pari	klawn Me Menora	emori	al Park	c´ i	1/04/	2008	Rock	ville,	Mar	vland	
Baltimore,	+ + + =		21	. Signature of Funeral Service	Licensee	and				ss of Facility L. Funera					1141	y zana	
m	permi Depar Impor any Ir			ala	e Wom	e(1)	1	1800	New Har	npshire	Avenu	e, Silv	er Sp	ring,	Mary	1and 20	904
	ELE		23	Ba. Part1. Enter the disease, o shock, or heart failure. Sis	or complications that cau	sed the deat	th. Do not en	ter the m	node of dyin	ıg, such as car	rdiac or r	espiratory a	rrest,			Approximate Interval Bet	e ween
	Physician		Im	mediate Cause (Final sease or condition	on our sause on our	1.0	erdial	_								Onset and I	Death
	/Medical		re	sulting in death)	a. Due to (or	as a conseq	juence of):	-100	twell	200					+-	minu	
	Examiner		0-		b												
	n =	ner	if a	quentially list conditions, iny, leading to immediate use. Enter Underlying use (Disease or injury at initiated events		as a conseq	uence of):										
	nd trans	Examiner	Ca	use (Disease or injury at initiated events sulting in death) Last	C												
30,	e exe sian a urial-		10.	diting in death) Last	Due to (or	as a conseq	uence of):										
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	/edical			d										-		
	ertific ling p e as		IF	FEMALE:													
Вох	eath cert attendin	ian/		b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐ Live birtl	n 2 □ Feta	al death 3[pregnancy	/			1	23d. Date o Month		-	Year
	the a	Physician/		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow		death 5	Other	(specify)								
P.0	that the dended by the detached	Ph)	Pai	rt II. Other significant condit	ions contributing to deat	h but not res	ulting in the u	ınderivin	n cause niv	en in Part !		23e Did to	obacco i	ise contribu	ite to th	e cause of d	ieath?
Records,	ires t signe d be c	by		The section original contact	enter continuous ground		and an area	indonym,	g daese g.v.	orran rants.						ably 4 🔀 u	
Ö	w requires been signe should be	Completed	_								_						
3ec	e law has t	ldu	_								_	24a. Was		24b. Wei prio dea	r to cor	psy findings a npletion of ca	available ause of
a		S		<u></u>								1□ Yes	2 ☑ No			2□ No	
Vital	sician: certific rector,	Be	25	Was case referred to medica examiner?	Hospital:				DOA Othe	26. Place of							
0	d is	То :	27	1 ☐ Yes 2 ☐ No Manner of Death	1 ☐ Inp		ER/Outpatie		DOA	4 LI Nursir		5 Resid			Specify)	
n	fing After fune	ion	21.	1 Natural 5 ☐ Pendi		Day Year)	Injury	М	28c. Injur Worl	ya≀ k? Yes 2∐No		d. Describe I	now injui	y occurred			
is.	Attending r death. ector: After by the fune	icat		3 Suicide 6 Could	not be 290 Place of	iniury - At he	ome. farm. st			765 2 140		f Location /9	Street an	d Number	or Rum	l Route Num	pher
Division	after Dire	Certification:		4 ☐ Homicide determ	nined building	, etc. (Specil	fy)		,,			City or Tov	vn, State)	or ritara	TIODIC TYDII	ibor,
	spital ours neral filled		29	a. Certifier 1 E Certifyi	ing Physician: To the be	est of my kno	owledge, dea	th occurr	ed at the tir	me, date and p	olace, an	d due to the	cause(s	and mann	er as si	ated.	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		(Check only 2 ☐ Medica one)													3)
	To th within To th	Me	29	b. Signature and title of certific	er				29c. License	e number			29d. Da	te signed (A	Nonth,	Day, Year)	
	30			· AIL	0 - ma				000	64011	8		Jan	3	× ,	200	
	2		30.	Name and address of persor	n who completed cause of	of death (Iten	n 23a) (Type,	Print)	000	0 126	<u> </u>	J.	J=1101	7		0	
				Amit Kalan	5 mo 9	901	mediz	-41	ante	e number 6406	Rec	Kylie	mo				
	Sta		31.	Date filed (Month, Day, Year	32 Reg	istrar's Signa	ature	-									
	Reaistr	ar	1	JAN 0.7	JULIUS LABOR		75.0	TAKE.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

James Marshall Bar	1- For State	tate of Maryland	/ Department of Certificate of		lental Hygie	ene Reg. N	20	08 0129
Physician/ Medical Examiner		es Marshall	Barnett		Mo	ate of Death onth Day nuary 4, 20	v Year	3. Time of Death 0023 hrs
	4a. Facility Name (if not institution Harford Memorial Hos	on, give street and number)		4b. City, Town, or Loca Havre de Havre De Drace			4c. County of E Harford	eath
Funeral Director	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday) 75 Yrs	Months Days I	Hours Min.			Birthplace (State or Foreign Country) Lubbock , TX
any	462-42-7593 Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Loca			2/11/1	932	10d. Inside City Limits
*	DC N	/ A	Washingt	On 10f. Zip Code		100.0	Citizen of What	1 X Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	1841 Park Rd			20010			U.S.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X N	1 Yes 2	X No	as Decedent of Hispani res, specify Cuban, Me	xican, Puerto Rica	Yes or No- n, etc.)	White, 6	American Indian, Black, etc. Caucasian
hours afte natural", Examiner	15 Decedent's Education (Cn		npleted) 16a. Decede	Yes 2 X No sp nt's Usual Occupation (lost of working life. DO	Give kind of work of	done 16i	Specify: Co. Kind of Busin	
5-0036 led within 72 hour Hygiene. other than "natt the Medical Exau	Elementary/Secondary (0-12	5+		oanalyst	Nother's Name (Firs		Psycho	ology
1215- d be filed tental Hyg narked out event, the	E.M. Barnet 19a. Informant's Name/Relation	t	10b Mailin		Margueri	ite Cr	oss	State Zin Code\
MD 21 nd 2 should alth and Me im 27 is ma "aumatic er	Camille Bar		e 1841	Park Rd.	, N.W.	Wash.	D.C.	
Baltimore, permit. Pages I an Department of Hee Important: If ite	1 X Burial 2 Crematic		ate crematory or o	her place) eek Cemet	erv 2/8	/08 V	Vashin	gton, D.C.
Balti permit. Depart Import injury	21. Signature of Funeral Service	J. Cliste	un 74	100 Georg	ia Ave.	, N.W.	Wash	Service, Inc. D.C. 20012
Physician Medical Examiner	23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final diseas)	e on each line.		the mode of dying, such	h as cardiac or res	oiratory arrest,	shock, or hear	Approximate Interval Between Onset and Death
	or condition resulting in death) Sequentially list conditions,	b. Due to (or as a cons	<u> </u>	-			<u> </u>	
led nsit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e c.						
be executed ician and urial - transit	UNPENDED	d. X #MENDED TME	1/7/08,BMW,	MoCo		-		
68760 certificate bording physics as the but	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 23c. If yes, outco	me of pregnancy	etal death 3 E	Ectopic pregnancy		23d. Date of d Month	elivery Day Year
Box he death of the atter hed for u	1 Yes 2 No 9 U	nknown 9 Unknown		ther (Specify)	n in Part I.	23e. Did tobac	cco use contrib	ute to the cause of death?
S, P.O. puires that the signed by all be detacted by the detacted by F.C. by F						1 Yes		Probably 4 Unknown ere autopsy findings available
of Vital Records, lag Physician: The law requires the this certificate has been signeral director, page 2 should be no. To Be Completed						autopsy performe	d? de	or to completion of cause of ath? ✓ Yes 2 No
Vital Fysician: Sysician: Sysician: Sysician: Officector, political officector, politica	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital: 1 Inpati	ent 2 🗹 ER/Outpatier	Oth	Death (Check only er 4 Nursing Ho		sidence 6	Other:
	27. Manner of Death 1 Natural 5 Per	28a. Date of Inj (Month Day) Jan 3, 2008	ury 28b. Time of 2345 hrs				injury occurre to auto colli	
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fine-	3 Suicide 6 Co	uld not be	njury - At home, farm, str terstate/Express	eet, factory, office build			et and Number e) .1, Havre de	or Rural Route Number, City Grace, Md.
Divi To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	29a. Certifier 1 Certifying	Physician: To the best of n	amination and/or investig	urred at the time, date a ation, in my opinion, de	and place, and due eath occurred at the	to the cause(s) and manner a d place, and du	is stated. e to the cause(s)
Me S T S T S	29b. Signature and title of certif	and manner stated fier Since the man in the		29c. License nu O.C.M.E			9d. Date signed January 4, 2	d (Month, Day, Year) 2008
	30. Name and address of personna M. Vincenti, M.	on who completed cause of		1 Penn Street, Ba	altimore, MD 2			
State Registrar	31. Date filed (Month, Day Yea		ar's Signature	de la companya della companya della companya de la companya della				
DHMH 17 Rev 1/2001			ORIGIN	AL.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 2008 RONALD ROY BOWIE 01 06 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner lisburg 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1**∑** M 2□ F 70 03/22/1937 Maryland Director 212-34-0985 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No Director Worcester Pocomoke City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a or USA 21851 827 White Oaks Lane by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give X White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 □ Widowed 4 □ Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Healthcare 12 Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Bowie Laura Dill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 White Oaks Lane, Pocomoke City, MD 21851 Cecille H. Bowie Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐ Removal from State Salisbury Crematory 1/8/2008 Salisbury, MD 21804 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Holloway Funeral Home, P.A. 21. Signature of Fungal Service Licenses 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co sequence Physician/Medical Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of): 68760, physician the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the same should be detached Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 3 Probably 4 Unknown Vital Record 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the lirector, page 2 s autopsy Yes or Attending Physiclan: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 🔀 No 1 Inpatient 2 ER/Outpatient 3□ DOA funeral 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Division 1X Natural Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifie ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who com BA 10 100 E. CAKKON M.O. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 0 8 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 1, **Physician** 2008 4:30 P M Elizabeth Hoffman Bergmann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Apex Health Care Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** New York Months Days Hours 1 □ M 2 🕅 F 088-05-1148 1914 93 Director Aug Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County iral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 USA 2700 Barker Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ģ 3 N Widowed 4 □ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's County Elementary/Secondary (0-12) College (1-4or 5+) Library System Library Assistant 8 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the standard of the contract of the con 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Hoffman Unknown ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Kalmia Lee Ct. #301, Falls Church, VA 22042 Anne Isabel Coleman - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Buriaf 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery: 1/7/2008 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Michelle C Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MO1491 Part1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction **Physician** /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Heart Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cerebrovascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Artheritis autopsy performed? 1□ Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA ို 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 | Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3503 Perry Street, Mt. Rainier, MD 20712 Raman Tuli 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 7 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Prince George's Bowie 12205 Foxhill Lane If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Days Months 1 □ M 2 🛣 F Oct. 4, 1926 Georgia 81 231-26-5221 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 □ No Prince George's Bowie MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20715 12205 Foxhill Lane 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Vesta Hester Kitchens Eugene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Foxhill Lane Bowie, MD. 12205 Susan E. Caffrey / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 □Removal from State Metropolitan Crematory 01/03/08 Alexandria, VA. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home Bowie, MD. 20715 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PFUSEL Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28b. Time of

Examiner The law requires that the death certificate be executed burial-trar and Division or Vital Records, P.O. Box 68760, physician the attending pt þ signed by been page 2 s has certificate I or Attending Physician: director, this

funeral After death. the Funeral Director: npletely filled in by the To the Hospital within 24 hours a

Physician /Medical

Examine

Director

Funeral

Completed by

Be

ဥ

Examiner

Physician/Medical

ş

Completed

Be

Certification: To

Medical

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notifiled at

72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

be filed within

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than

or other permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.

Physician /Medical

> 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No М 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

(Item 23a) (Type, Print)

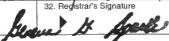
State Registrar

completely

ျှ

2008

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6 2008 10:20 p^M Dahlia Colaw Barrett January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frostburg MMHS-Frostburg Nursing & Rehab Center Allegany ocial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F Days Hours Min. 214-03-5678 99 Director July 06, 1908 West Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Items 23a or 28a-f show ner must be notified at 1 XYes 2 □ No Director Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 East Mechanic Street U.S.A. 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status "natural", or Item edical Examiner 1 Yes 25 No If Yes, Givel Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 █ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the waitress restaurant other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be I Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic every **Ernest Colaw** Blanche Burger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois E. Cunningham 21532niece Maryland Frostburg 176 Mount Pleasant St. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory January 07, 2008 Cumberland Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility tin Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 0 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) FAILURE **Physician** Leart ONGESTIV months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Dementia 2 1 No 1 🗌 Yes 3 Probably 4 Unknown Completed Sterro Suo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 autopsy performed?/ yes 2 \(\text{P}\) No certificate 1 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 24 hours after death. 5 Pending investigation 1 ☑Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death • Funeral Director; the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. To the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 amon

DHMH 17 Rev 1/2001

State

Registrar

TIRS

Frest burg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CHANG, M.D

31. Date filed (Month, Day, Year)

JAN 0 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ľ	For State Registrar	oraro or maryro		rtificate of L		Re	eg. No.2	008	01296
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Deat Month		Year	3. Time of Death
	/Medic		-10-11-11-1	CHERINE	BRADY			01	02	2008	1256 P M
B	Examin	er	4a. Facility Name (If not institution, gi MEMORIAL HOSPITA	,		4b. City, Town, or CUMBER		h		LEGANY	
-	Funeral		5. Social Security Number 6.	Sex 7. Age (In yi	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.			9. Birthp	lace (State or Foreign
L	Director		220-07-0002	¹ □M ² X̄F 89	Yrs.	Months Days	Hours Min.	(Month, Day, 04/08/1		West	Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				1	0d. Inside City Limits
	Maryl f sho	to	MD Alle	gany	C	umberland	1				1 X Yes 2 □ No
	n 28a n notifi	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizer	n of What Coun	ntry?
	23a c ust be		1611 Nellie S	Street		2	1502		U	SA	
	er deg	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14.	. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Sį	pecify:	
2-0036	"2 hou latura lcal E	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/Inc	nite dustry
21	ithin 7 ne. nan "r	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired))	rking	_		_
2	lled w lygier her th nt, the	S	17. Father's Name (<i>First, Middle, Las</i>	4)	C	o-Owner	19 Mothada Nor	me (First, Middle, M		surance	Co.
anc	be od o) Be		*	Lechlite	er	Anna	Elizal		· _	pson
Maryland 21	W = 3	으	19a. Informant's Name/Relationship			ng Address (Street a					·
	7 is		Felix R. Brady /	Husband	1611	Nellie S	treet, C	Cumberlan	d, MI	2150	2
altimore,	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	Place of Dispo cemetery, cres	sition (Name of matory or other plac	e)	Date	20c. Locat	tion - City or To	own, State
Ē	Pages tment of l tant: If It		4 Donation 5 ☐ Other (Spec	ify) H	illcrest	t Mem. Pa	rk 1/5/	2008	Cumb	erland	, MD
Ra	permit. Page Department Important: If any Injury or		21. Signature of Funeral Service Life	adamy		2. Name and Addres 404 Decat					Home, P.A. 2 1 502
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	inplications that caused the de y one cause on each line.	eath. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory arre	est,		Approximate Interval Between
	Physician /Medical		immediate Cause (Final disease or condition resulting in death)	a Acute F	Reval	Failu	re			o	Onset and Death
	Examiner		1	Due to (or as a cons							10.15
	10	Jer	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con)						C	ray 5
	ocuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
60,	rificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
98760	ficate physics the	Medical		d .							
ROX	leath certi attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf preg		75-4			230	d. Date of delive	ery
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown		∃Ectopic pregnancy ∃Other (spe <i>cify)</i>	-			Month	Day Year
J.	that the		9 ☐ Unknown Part II. Other significant conditions	contributing to death but not r	esulting in the u	nderlying cause give	en in Part I	23e. Did tob	nacco use	contribute to the	ne cause of death?
Hecords,	w requires that the de been signed by the should be detached	Completed by	Dementia	-							pably 4 □Unknown
Ö	w red s beer shou	lete						24a. Was ai	n 2	24b. Were auto	psy findings available
	sician: The law certificate has birector, page 2 s	omp						autops perforr 1 Yes 2	ned?	prior to cor death?	mpletion of cause of 2 . ™ No
VITal	ctor, p	Be C	25. Was case referred to medical examiner?					ath (Check only on			
20	Physician: r this certific ral director,	၉	1 Yes 2 No		☐ ER/Outpatien		4 Nursing F	lome 5 ☐ Reside			y)
	D 0 0	tion:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	/at ⟨? Yes 2∐No	28d. Describe ho	ow injury o	occurred	
UIVISION	r Atter ter deat irector irector by the	Certification:	3 Suicide 6 Could not be determined	De I 290 Place of injury At	home, farm, str			28f. Location (St. City or Town	reet and h	Number or Rura	il Route Number,
ב	pital o urs aft eral D		Consider the Considering B	husialan. To the book of well		b					
	To the Hospital of within 24 hours aff To the Funeral D completely filled in	Medica	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my k miner: On the basis of exami and manner stated.	mowiedge, deatlination and/or in	vestigation, in my o	ne, date and place pinion, death occ	e, and due to the ca urred at the time, d	ause(s) ar ate and pl	nd manner as s lace, and due to	tated. o the cause(s)
	To the Within To the compl	Me	29b. Signature and title of certifier		(-	29c. License	number	29	9d. Date s	signed (Month,	Day, Year)
ł	(3)		July	Halken	_ h	D544	11		Janu	uary 3,	2008
(90	İ	30. Name and address of person who		/						
,	ILOU		BEVERLY CALKINS 31. Date filed (Month, Day, Year)	M.D. 500 M		AVE., CU	MBERLAND), MD 215	02		
	Sta Registr		IAN 0 3		H	land.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 10, 2008 4:50 P.M John Joseph Brenneman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Accident 218 S. Main St. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**⊠**M 2□F 216-22-5990 Apr 17, Director 1927 Maryland 80 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f ahow othar traumatic evant, the Nedical Examinar must be motified at 1 XYes 2 ☐ No Director Accident MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21520 USA 218 S. Main St. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiene. Is marked other than "natural", or ita 1 X Yes 2 □ No If Yes, Give WW 2 Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ₩ Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Well Drilling Co. Owner/operator 8_th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elsie Belle Lee Aubrey C. Brenneman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Is n any injury or other traun <u>once.</u> 312 Main St., Extended, Accident, MD Larry Brenneman/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ^4 ☐ Donation 5 ☐ Other (Specify) St. John's Luth. Cem Jan 14, 2008 Accident, MD 21. Signature of the I Service 22. Name and Address of Facility Newman Funeral Homes, P.A., P.O. Box 275 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. New Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Non Hodgkins Lymphoma Due to (or as a consequence of): yrs /Medical Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. be detached JYes 2 □ No signed by the 9 Unknown The law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 2 X No 1 Yes 2□ No Division of Vital Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 2 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To tha Funaral Diractor: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation M or Attand after death Diractor: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signathre and title of certifier D30035 01-10-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Donald R. Richter, M.D. 1533 Memorial Drive Oakland, MD 21550 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 15 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of		nd / Depa		t of H	ealth a				008	01298
	Physici		Decedent's Name (First, Middle, La Ralph James Brown				· -				2. Date of Dea Month Januar		2008	3. Time of Death 8:00 P. M
	/Medic Examin	i	4a. Fecility Name (If not institution, given Goodwill Mennon:		per))		Location o				unty of Death	
	Funeral Director		172-18-3036	177M 2 17 E	Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Jan 10	h v, Year) , 1918	9. Birth Cou B Penr	place (State or Foreign ntry) nsylvania
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County PA Somerse	ot.		ty, Town or Lo								10d. Inside City Limits
	with the a or 28a-	Direct	10e. Street and Number 112 Washington A			2110001	10f. Zip	Code 155	5Ω				n of What Cou	intry?
36	d within 72 hours after death with the Maryland Jiene. I then "natural", or iteme 23a or 28a-f show The Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2√2 Married	12. Was Deced Armed Forc 1 Pyes 2 If Yes, Give	es? ∐No M/M/	_	Was Deced II Yes, spec	dent of Hi cify Cubar		gin? (Spe n, Puerto I	ocify Yes or No Rican, etc.)	. 14.	Race - Ameri Black, White	, etc.
215-00	within 72 hours ene. then "natural" he Medical Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12)	Year or Date ducation ade completed) College (1-4	es:	16a. Dece		al Occupa	ition luring most	t of workin	ng		ol Business/Ir	
Maryland 21215-0036	be filed tal Hyg d othe event.	То Ве Соп	12 17. Father's Name (First, Middle, Las. Harvey M. Brown	")		Surve	yor				(First, Middle,	Penn Maiden Su		
_	alth and 27 is m		19a. Informant's Name/Relationship Nick B. Brown/so			1605	Pitts	burg		e., N	Route Numbe	ke Pai	ck, MD	21550
Baltimore,	permit. Pages 1 a Department of He Important: If item any njury or othe		20a. Method of Disposition 1 ☐ Buriat 2 ☑ Cremation 3 [4 ☐ Donation 5 ☐ Other (Special Control of	(y)	ate	Place of Dispondentery, creation	natory or o	crem.	. Jai	n 12	, 2008	Davi		e, PA
■ Bal	Depring any r		21. Signature of Fund al Service Lice 23a. Part1. Enter the disease, or conshock, or hear failure. List only	eumac		91	.68 Ma	son-	Dixor	n Hwy	Inc., , Sali	sbury		5558 Approximate
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. <u>Conge</u> Due to (or	stive	Heart	Failu							Interval Between Onset and Death 1 year
,092	cate be executed physician and ; the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Chron	nic Rer	nal Ins	suffic		h-	Disea	ase			2 years 2 years
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∐Feta ntattime old	al death 3[]Ectopic pr] Other (sp					230	I. Date of delik Month	very Day Year
<u>α</u>	The law requires that the te has been signed by thisge 2 should be detache	ρ	Part II. Other significant conditions <u>Diabetes Mellit</u>			sulting in the u	nderlying c	ause give	en in Part I.			obacco use /es 2 🗆 t		the cause of death?
al Records,		Completed				_					24a. Was autor perfo 1 Yes	rmed?	24b. Were aut prior to co death? 1 Yes	opsy lindings available ompletion of cause of
of Vital	Physician: T this certificat al director, pa	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Ing		ER/Outpatier			r: 4 🗐 Nu	ırsing Hor	THE SERVICE THE SE	dence 6		ify)
Division	Jing After fune	Certification;	1 ∰Natural 5 ☐ Pending 2 ☐ Accident investigatic 3 ☐ Suicide 6 ☐ Could not to determined	(Month,	Day Year)	Injury	М		(? /es 2 ☐	No		Street and N		ral Route Number,
	Phospital or Attend 24 hours after death Funeral Director: etely filled in by the	dical Cer	2 Gentilier 1 Ly Certifying P	hysician: To the b miner: On the bas	est of my kn	cwladga deat	h occurred	at the thi	e, date an	id place, a	and due to the	causa(s) on	d manner as	stated: to the cause(s)
	To the Hos within 24 ho To the Fund completely f	Med	29b. Signature and title of certifier	and manne	or stated.	1.,	290	c. License	number			29d. Date s	igned (Month	, Day, Year)
7	1	8	30. Name and address of person who			# CO. N.	Print)	00058					1, 200	J
	Sta Registr	te	Sabahat Nawab, I 31. Date filed (Month, Day, Year) JAN 15	32. Re	Corpoi fistrar's Sign	ature _	ive,		rtsvi.	TTE'	MD 21	536		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Bounds 11:40 January 07 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Hopkins Baltimore City None | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Oct 7, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2 🛛 F Maryland 213 03 9500 87 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 □Yes 2 No Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9122 Winding Way 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Janssen Mae Koontz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James M. Bounds/Son 9122 Winding Way Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Gard. 1-11-2008 | Marriottsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 (g 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications viat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myccardial Inferction 36 hi Due to (or as a consequence of): ate of delivery Month Day Year

3 Probably 4 Munknown

Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq Yes \) 2 \(\subseteq No \)

2008

January

Physician /Medical Examiner

and

ed by the attending physician detached for use as the buria

s been signed by t should be detach

this

l Director: d in by the

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

show

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "n any injury or other traumatic event, the Medionce.

Director

Funeral

þ

Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner Physician/Medical 9 Completed Be (

29a. Certifier

(Check only one)

John Burger

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

	Sequentially list conditions, if any, leading to immediate cause Endemotiving Cause (Disease or injury that initiated events resulting in death) Last	b						
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet: 4 ☐ Pregnant at time of o	al death 3 □Ectopic	c pregnancy (specify)			23d. Date of delivery Month Day	Year
	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in F	art I.	23e. Did tobacco u 1 ☐ Yes 2[se contribute to the cause	of death? ⊡ Unknov
						24a. Was an autopsy performed? 1∐ Yes 2 ₭ No	24b. Were autopsy findir prior to completion death? 1 □ Yes 2 □ No	ngs availal of cause o
ı	25. Was case referred to medical examiner?			26. F	Place of Death (Check only one)		
ı	1 ☐ Yes 2 📉 No	Hospital: 1 ⊠Inpatient 2 □	ER/Outpatient 3□	DOA Other: 4 [Nursing Home	5 ☐ Residence	S □Other (Specify)	
	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	280	d. Describe how injur		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office	281	Location (Street and City or Town, State)	d Number or Rural Route N	Vumber,

within 24 hours a.v.

To the Funeral Dir

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Hospital. 32. Begistrar's Signature

Burgua, Medical Doctor

Johns

JAN 0 9 2008

600 North Wolfe Street.

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Kes- 000

			For State Registrar		State of Ma	aryland /		rtment of F <i>tificate of i</i>				iene g. No. 2 A A	Ω	01200
	Physici		Decedent's Name	(First, Middle, Last	Bangha	rt				2. [Date of Death	- 	ar a	2-20 PM
4	/Medic Examir		4a. Facility Name (If r	not institution, give	street and Jumber)			4b. City, Town, or	r Location		<i>(</i>	4c. County of D		
5	LAGIIII	101			eral Hosp	nital		Columb	nia			Howard	3	
2.5	Funeral		5. Social Security Nur			e (In yrs. last bi	irthday)	If Under 1 Year	If Under	24 Hrs. 8. C	ate of Birth	9	Birthplace	e (State or Foreign
	Director		218-58-14	132	^{]м 2} ХГ 6	57	Yrs.	Months Days	Hours		Month, Day,		(Country Sustr	alia
	Þ	2	Usual Residence of D	Decedent							-			
	rylar how	_	10a. State	10b. County		10c. City, Tow	vn or Lo	cation						Inside City Limits
	e Ma Sa-f s tiffiec	양	MD	Howard		Colum	nbia							1 ☐ Yes 2X No
	ith th or 28 e no	Sire	10e. Street and Numb	ber				10f. Zip Code			10	g. Citizen of What	Country?	?
	23a ust b	la I	5450 Phel	lps Luck	Drive			21045	5			United S	State	s
(0	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie	d 2 X Married	12. Was Decedent Armed Forces? 1 Yes 2X			Vas Decedent of H f Yes, specify Cuba			Yes or No- n, etc.)	14. Race - A Black, W	merican l /hite, etc.	
036	urs a al", o Exan	by	3 ☐ Widowed 4	□Divorced	If Yes, Give Year or Dates:		1	∐Yes 2∰2 No	Specify:	•		Specify: V	Thite	:
215-0036	72 ho	Completed	(Specifi	15. Decedent's Edu y only highest grad	ication	16a	a. Deced	ent's Usual Occup	ation	et of working	1	16b. Kind of Busine	ss/Indust	try
218	thin 7	ed (Elementary/Second		College (1-4or 5	i+)	life. L	kind of work done OO NOT use retired	d)	st of working				
2	filed within Hygiene. other than "	[등			5+		Tea	acher				Educati	on	
	be file	Be (17. Father's Name (F							,		faiden Surname)		
/la	should be and Mental Is marked o	흔	George Gi	ilbert					Oli	ve Asht	on			
Maryland	2 sho and I is ma		19a. Informant's Nan									City or Town, Stat		de)
	1 and 2 Health tem 27 i		Leslie L.	. Banghar	t/Husband	1 5	3450	Phelps I	Luck 1	Drive C	olumb:	ia, MD 21	.045	
nore	Pages 1 nent of Ha ant: If iter			Cremation 3 🗆 F	Removal from State	cemete	ery, cren	sition <i>(Na</i> me of na <i>tory</i> or other plac rematory		Date 1-8-200	į.	20c. Location - City Hanover ,		State
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fund	other (Specify) oral Service Licens		M01044		-	i_			tzke's Fa		FH Inc.
8	9 3 E 6		Show	lollis.	- Mysy	the test De	41:	12 Old Co	olumb:	<u>ia Pike</u>	Ellic	cott City	, MD	21043
			23a. Part1. Enter the shock, or heart		ne cause on each lir			-	ng, such as	s cardiac or res	piratory arre	·SI,	1 Int	proximate terval Between nset and Death
Ť.	Physician		Immediate Cause (Fi disease or condition resulting in death)	inai	a	5e	اكاوا	2						
1	/Medical Examiner		resulting in death,		Due to (or as	a consequence	of);	Pena	1 Fa	· luse				
H.	4	7.	Sequentially list cond	ditions,	b. Due to (or as	nollya	MC	, ACTION	1/4	.11000				
	ted nsit	Examiner	Sequentially list cond if any, leading to immorause. Enter Underly Cause (Disease or in that initiated events	ying jury	(/)	ente ()	naal	Rena intot	mel	12000	<i>(</i> ,			
	The law requires that the death certificate be executed te has been signed by the attending physician and page 2 should be detached for use as the burial-transit	xar	that initiated events resulting in death) La	st	c. Due to (or as	a consequence	of):	-0 (1 -0-0		0 00			+	
68760,	siciar buri	al			4									
89	ificate g phy as the	edical			u									
Вох	death certifi attending p	N/M	IF FEMALE: 23b. Was decedent p	oregnant 2	23c. If yes, outcome							23d. Date of	delivery	
ĕ	death atte	sician/M	in the past 12 m 1 Yes 2	nonths?	1∐Live birth 4⊡Pregnant at			Ectopic pregnancy Other <i>(specify)</i>	y			Month	Da	y Year
P.0	that the de led by the a detached	Phys	9 ☐ Unknown		9□ Unknown									
	res that signed b	by PI	Part II. Other signific	ant conditions co	ntributing to death b	ut not resulting i	in the un	derlying cause give	en in Part I	I. :	23e. Did tob	acco use contribut	e to the c	ause of death?
or Vital Records,	quire n sig uld bu	d b									1	s 2 No 3] Probabl	y 4 Unknown
၀	tw requires been so should	Completed									24a. Was ar	24b. Were	autopsy	findings available
Be	The lav e has age 2 :	Jmc									autops	ned? prior deat	to comple h?	etion of cause of
tal			25. Was case referre	ed to medical					26 Place	e of Death (Ch		1 1 1	res 2L	No
>	ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 N	/	Hospital:	nt 2 ☐ ER/O	utnatien	t 3□ DOA Oth	er.			nce 6 Other (5	Speciful	
0	ding Physician: The n. After this certificate his funeral director, page		27. Manner of Death		28a. Date of Inju	ry 28b.	Time of	28c. Injur Worl				w injury occurred	респу)	
ion	nding F th. r: After e funera	iţi	1	5 Pending investigation	(Month, Day	y rear)	Injury		K? Yes 2 □]No				
Division	Attence or death rector: by the	fice	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju	ury - At home, fa	arm, stre	et, factory, office	-			eet and Number of	r Rural Re	oute Number,
ā	alor safte N Dir	Certification:	4 [] Horricide		building, etc	с. (Бреспу)					City or Town	, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 (Check only 2	Certifying Phy	sician: To the best of	of my knowledg	e, death	occurred at the tir	me, date a	nd place, and o	due to the ca	use(s) and manne	r as state	id.
	the H hin 24 the F mplete	Medical	one)		and manner sta	ated.								
	5 × 5 0	2	29b. Signature and tit	C A				29c. Licens	20 L/		29	d. Date signed (M	onth, Day	(, Year)
~				E U am	70			<u> </u>	2004	ri 	1	anuay	8	1000
(5))OP		30. Name and address Ramer Sa. 31. Date filed (Month)	ss of person who co Capathi	ampleted cause of de 201-109	eath (Item 23a)	Riv.	il Neck	Load	d Bai	1/mo	re May 1	and.	2/221
	[∜] Sta Registr		31. Date filed (Month	Day, Year) AN 0 9 20	32. Registra	ar's Signature	A	and a						
			0.	5 5 6	Mark States	The state of the s	1	AL THE						

State of Maryland / Department of Health and Mental Hygiene 1- Registrar Amend Items 25,27,28a-f per me 8875 01/25/08/hb 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Year Month **Physician** \mathbf{A}^{M} 0600 RUTH AUDREY BEAUCHAMP JANUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
FEB. 14, 1940 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🙀 F Yrs. 67 MARYLAND Director 214-38-5668 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural" ——any illury or other fraumatic events. 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No Directo **QUEEN ANNE** QUEENSTOWN MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21658 USA 101 PROUSE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OFFICE MANAGER 12 -0-HOSPICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARL LUND DOROTHY QUAIL ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WILSON NELSON BEAUCHAMP/HUSBAND 101 PROUSE ROAD, QUEENSTOWN, MARYLAND 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE CEMETERY STEVENSVILLE, MARYLAND 1-7-2008 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 408 S. LIBERTY ST., CENTREVILLE, MD Part1. Enter the disease, or complication shock, or heart failure. List only one reat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Immediate Cause (Final **Physician** hypercarbic disease or condition resulting in death) Due to (or as a consequence of): /Medical **Examiner** ohes morbid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine CERTIFICATION APPROVED BY SE that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached t 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Urosepsis 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an renal autopsy certificate fractured 2 No the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ₹ 1 € 1 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 12/15/2007 **Unknown**^M Subject fell. I Director: d in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 101 Prouse Road 4 Homicide determined thin 24 hours a Queenstown, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) (exo) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

 $\# \mathcal{J} \mathcal{J} \mathcal{T}$ Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Rose Μ Boord January 2008 9:16 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 □ M 2 🐼 F 74 Yrs Feb. 14, 1933 Pennsylvania 169-26-6644 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 To Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Prospect Blvd., Apt/7-C 21701 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 ☑ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home (7 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk.) Srbinovich 19a. Informant's Name/Relationship (Type. Print)
_____, Personal 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 P.A. 127 W. Patrick St. Frederick, MD Doug Thornton, Esq. Respesentor Stern & Thornton, 20b. Place of Disposition (Name of cemetary, crematory or other place)
Resthaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 Other (Specify) 2008 Frederick, Maryland neral Service Liceur e 21. Signature 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 Due to (or as a consequence of): rubable Sequentially list conditions, it any, leading to it in replact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Due to (or as a consequence of): IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | R/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury

Physician /Medical Examiner Examiner requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

show

7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i

72 hours after

d 2 should be filed w h and Mental Hygier ? is marked other th

permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traum

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

or Vital

Division

at r 28a-f sh notified

Director

þ

Completed

Be

2

burial-trar physician as the attending use for the signed by t page 2 s certificate I director this funeral After Hospital or Attending 24 hours after death.

Physician/Medical

2 Completed Be 2 Certification: the Funeral Director: Af

Medical

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

4 Homicide

6 ☐ Could not be

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number D0060417 29d. Date signed (Month, Day, Year) 1-4-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hemen Shall 31. Date filed (Month, Day, Year)

2008 JAN 08

Thomas 65 0 32 Registrar's Signature

Tohnson Dr. Frederick MD 21702

the within

0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Betty Marie Barrett Janaury 12, 2008 5:00 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 229 Forest Green Road Aberdeen Harford Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 220-22-1718 1 □ M 2 🗙 F June 2, Director 1927 80 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10h. County 10d. Inside City Limits r 28a-f show notified at MD Harford Director Aberdeen 1 ☐Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or dical Examiner must be r 229 Forest Green Road 21001 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or iter any injury or other traumatic event, the Medical Examine anay injury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 ☐ MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 17. Father's Name (First, Middle, Last) Be (18. Mother's Name (First, Middle, Maiden Surname) Elsie Btodshaw John Friend ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Stonebraker (Daughter) 677 West Bel Air Ave. Aberdeen MD 21001

Date Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 DCremation 3 ☐ Bernoval from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co. 1/15/08 West Chester, PA 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P
Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licenses P.A. 23a. Fart1. Enter the disease, or count cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Yea 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 1 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Canlyn C. Houk M.D.

Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARDLYN C. HOUK M.D. JOHNS HOPKINS CRIVERSIDE

32. Registrar's Signature

D0051720

JANUARY 14# 2008

1321 RIVERSIDEPARKWAY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** rene January 2008 4 /Medical 4a. Facility Name (I not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Berlin Worces MdNUVSING Home 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 217-05-4149 Hours 88 20-19 Director BISMARK, N. D. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits пs 23a or 28a-f show must be notified at 1XYes 2 No Ocean Worcester Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12820 Whis per Trace dr. U.S.A 21842 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give/ Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗙 No Baltimore, Maryland 21215-0036 Specify: Completed by 3XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ARCROSE CORP. Elementary/Secondary (0-12) College (1-4or 5+) PackER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raitt RESSIER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 12800 ...
2010 Place of Disposition (Name of cemetery, crematory or other place) Ocean City, md 21842 ane P. Snyder Whisper Irace Dr. 20a. Method of Disposition Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 1-8-08 4 □ Donation 5 ☐ Other (Specify) Capital Crematory Dover 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

Bennie Smith 917 W. I Sabella St Salisbury, md 2180 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final Cardiovaxenter **Physician** eroselestre disease or condition resulting in death) eus /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the bunial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No eutopsy performed? 1□ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 1 Tes 1 Inpatient P 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury Work 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation M 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 29b. Signature end title of 29d. Date signed (Month, Day, Year) Coostal Hayling Fanwick Tolerd, De 1994 1209

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	_ FUI	partment of Health and N ertificate of Death		ene2 0 0 8	01305
	-		Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
п	Physici		Philip Howard Cease	r	January	11 2008	1853 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	·	4c. County of Deal	h
			Union Hospital	E1kton		Cecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birt	hplace (State or Foreign untry)
	Director		153-20-2275 ¹ X ¹ M ² □ F 76 Yrs	. Internal Days	FEB 19,	1931 New	Jersey
	pu *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	eho e	5					1 ☐ Yes 2] No
	the N	Director	Maryland Cecil Elktor	10f. Zip Code	10	g. Citizen of What Co	juntry?
	with be or	급	50 Chestnut Drive	21921		United S	•
	eath	Funeral		3. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	
	fter d	ᆵ	Armed Forces? 1 □ Never Married 2 □ Marned 1 ▼ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
ဗ္ဗ	urs a	þ	3 💢 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: E	lack
Ŏ	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f ehow int, the Madical Examinar must be notilled at	Completed		cedent's Usual Occupation ive kind of work done during most of work		6b. Kind of Business	Industry
7	thin 7	ed l	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)	9		
7	ed wi	Son		elivery Driver		Corporat	e
פ	tal H d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, M	laiden Sumame)	
<u> </u>	Men Merke Marke	ဥ	William Ceaser	01ive			
Jar	2 sh and Is m	İ		ailing Address (Street and Number or Rur			ZIP Code)
6	l and tealth im 27	-		Chestnut Drive, Elk		21921 Oc. Location - City or	Town State
0	H of H		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, of	rematory or other place) Janua	ary 14,		
Baltimore, Maryland 21215-0036	t. Partmer			is & Co., Inc. 2008	V	Vest Chest	er, PA
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene traducal, or Items 23a or 28a-f show morportant: If them 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	Hicks Home for Fune 103 W. Stockton St.	rals, P. . Elkton	A. . MD 21921	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ry arrest			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):)			
	Examiner	_	Sequentially list conditions, b. End Ste	ge COPD.			
	p #	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	O			
> .	and I-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	cate be executed physicien and s the burial-transit	a E					
687	ficate p phys	edical	d				
Вох	nding use a	M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	ivery
Ď.	that the death certifit ed by the attending I detached for use as	Physician/Me	in the past 12 months? 1 Vec 2 No. 1 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)		Month	Day Year
P.O.	of the by the tache	hys	9 Unknown				
ś	as the	by F	Part II. Other significant conditions contributing to death but not resulting in the		1	acco use contribute to	
D.C	w requires t been signe should be	ted	Chronory arery are	-e016	192Ye	s 2□No 3□P	robably 4 Unknown
Division of Vital Records,	a 20 C1	Completed			24a. Was ar autopsy	prior to	topsy findings available completion of cause of
<u> </u>	The page	Sol			perform 1 Yes 2	ed? death? DNo 1 ☐ Yes	2□ No
/ita	iclen: ertific ector,	Be	25. Was case referred to medical examiner?	Others	th (Check only one	o)	
ō	Physical this cal dir	J.	1 ☐ Yes 2 No		ome 5 ☐ Reside	nce 6 Other (Spe	cify)
L C	ding After funer	- Lo	Natural 5 Pending (Month, Day Year) Injur		200. 0030100 110	w injury occurred	
isi	deat deat ctor: y the	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm.			eet and Number or R	ural Route Number,
<u>S</u>	tal or / rs efter el Dire ed in b	Certification:	4 ☐ Homicide building, etc. (Specify)		City or Town	, State)	
	To the Hospital or Attending Physicien: The I within 24 hours sider death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner at te and place, and due	s stated. to the cause(s)
	To the virthing to the comp	×	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	h, Dey, Year)
)			(bloggered)	10000043	90	111010	208
	\		30. Name and address of person up completed cause of death (Item 23a) (Ty		G(). 1-	110 0	1001
	\		Opten Coksoygon 223	w main st.	C1C401	11111 2	17121
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	salle)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Year Mthony Colagiovanni January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospita Baltimore 6. Sex 1**X** M 2□ F 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours **Director** 57 296-48-2237 June6,1950 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits r 28a-f show notified at Show 1 ☐ Yes 2 ☑ No Lititz Directo Pennsylvania Lancaster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or r r must be r 321 Coventry Lane 17543 U.S.A. Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. unt: If item 27 Is marked other than "natural", or items 23s item 27 Is marked other than "natural", or items other traumatic event, the M disal Examiner man 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Biack, White, etc. 1 Ma Yes 2 □ No if Yes, Give Year or Dates: 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify:White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Produce Purchaser 10 Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Anthony Colagiovanni Christin<u>a Nero</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Colagiovanni/Wife 321 Coventry Lane, Littiz, Pennsylvania 17543 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All Souls Cemetery 1-18-08 Chardon, Ohio 22. Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee mar 6009 Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** Due to (o as a consequence of) days /Medical resulting in death) Examiner isseminated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division or Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Peath Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No • Hospital or Attendi 24 hours after death. • Funeral Director: A etely filled in by the fu death. 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Medical Doctor KES-000 January 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Bisrat K. Abraham, The Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland 21287 State Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEW 2 per UR C875 1/23/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 520 PM T. Iona Courtney January /Medical 4b. City, Town, or Location of Death 4c. County Facility Name (If not institution, give street and number) Examiner Grace Hartoro Havre If Under 24 Hrs. 8. Date of Birth (Month, Day, June 7, 7. Age (In yrs. last birthday Year 9. Birthplace (State or Foreign Social Security Number Funeral Months Days Hours 1 M 200 June Director 95 1912 North Carolina 228-16-2059 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 10b. County at 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 TNo Director MD Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3747 Aldino Road 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: Specify: <u>ک</u> 3 ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilborn Thompson Zollie Greer ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Lou Gallion (Daughter) 3747 Aldino Rd. Aberdeen MD 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 nent of H int: If ite ury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or 4 □ Donation 5 □ Other (Specify) Harford Memorial Gdns. 1/21/08 Aberdeen, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. Lara Ma Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that covered the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on any hilling. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year signed by the and be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼No 24a. Was an autopsy perform To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide f 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) Mounte 30. Name and address of person who corporeted caus of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 Registrar

Physician /Medical Examiner

permit. Pages 1 Department of H Important: If ite any Injury or of

Physician

/Medical

Examiner

Director

þ

Completed

Be

2

Funeral

Director

ral", or items 23a or Examiner must be

"natural",

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

within 24 hours after deatl To the Funeral Director;

	resulting in death)	a. Theur Forna			
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	remia_		
ysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		topic pregnancy her (specify)	23d. Date o	,
ed by Ph	Part II. Other significant condition	s contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco use contribu	
Complet				autopsy prio performed? dea:	re autopsy findings available r to completion of cause of th?
Be (25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
10	1 ☐ Yes 2 🛣 No	Hospital: 1⊅ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Hon	ne 5 Residence 6 Other ((Specify)
ation:	27. Manner of Death 1 Manural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how injury occurred	
Sertific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		factory, office	8f. Location (Street and Number of City or Town, State)	or Rural Route Number,
Medical Certification:	29a. Certifier 1 ★ CertifyIng (Check only one) 2 Medical E	Physician: To the best of my knowledge, death or xaminer: On the basis of examination and/or investand manner stated.	curred at the time, date and place, a tigation, in my opinion, death occurred	and due to the cause(s) and manned at the time, date and place, and	er as stated. I due to the cause(s)
Me	29b. Signature and title of certifier		29c. License number	29d. Date signed (A	Month, Day, Year)

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

MIKUBKY

31. Date filed (Month, Day, Year)

JAN

1689877201

22 South Greene Street Baltimore, MD 21201

103/08

			For 1_ State	State of Ma	aryland					and Me	ental Hy	giene	20	00	013	
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Cei	rtificat	e of L	Jeath		2. Date of Dea	Reg. No	. <u>L</u> U	00	3. Time of D) U
	Physicia		DORIS L.	CROSS							Month JAN	Da		Year	1/1:00	PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City	Town, or	Location o		21114		. County		1, 17,00	+
			Renaissance Gardens -						er Spr				Prince	e Geor		
	Funeral		5. Social Security Number 6. S 215-22-3249	ex	e (In yrs. la 84	as <i>t birthd</i> ay) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	8. Date of Birt <i>(Month, Da</i> December	y, Year,		Coun		Foreign
	Director		Usual Residence of Decedent								December	29,	1923		aryland	
	show	_	10a. State 10b. County		10c. City	, Town or Lo	cation					e		1	0d. Inside City 1 ☐ Yes 2	
	he Me 28a-f otifie	Director	Maryland Prince Ge	orge's	ļ		10f. Zi		r Spri	ng		10a Ci	tizen of M	/hat Coun		
	with 3a or 1 be r	Dir	3160 Gracefield Roa	d #131/			101. 2.1	oode	20904	ı		10g. o.		.S.A.	,.	
	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Dece	dent of Hi			cify Yes or No- Rican, etc.)	-	14. Race	- Americ		
2	or ite		1 Never Married 2 Married	1 ☐ Yes 2 ☑ I If Yes, Give	No		n Tos, spo 1 □ Yes			i, i dono i	110411, 010.)		Specify		White	
5	hours tural"; al Exa	ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Dates:		16a. Dece	dent's Usu	al Occupa	ation			16b. k		siness/Inc		
2	nin 72 n "na Medic	Completed	(Specify only highest gra		(43	(Give		ork done d	luring most	t of workin	g	.00.1			,	
7	generation of the control of the con	Com	12				Н	omemak						Domest	ic	
2	be file	Be	17. Father's Name (First, Middle, Last)						18. Mothe		(First, Middle,		n Surnam	e)		
3	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	으	Frank Grime 19a. Informant's Name/Relationship (-		19b. Mailir	na Addres	s (Street a	and Numbe		ce Chane Route Numbe	-	or Town.	State. Zip	Code)	
<u>ס</u> ≥			Diane L. VanLonkhuyze			1	-				ckville,					
กั เ	es 1 and 2 of Health Item 27 I		20a. Method of Disposition	ID	C	lace of Dispo emetery, crei	matory or	other place	e)	Da	ate	20c. L	ocation -	City or To	wn, State	-
=	Pages ment of H ant: If Ite ury or of		1 ⊠ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	y)		gan Chap nodist (ery	01/08	/2008	Wo	odbine	e, Mar	yland	
Daltillor	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service Licer	isee) -	\ .	l H i	ines-R	inaldi	s of Facility Funer	al Ho	me, Inc.					
	E0 = 60		23a. Part1. Enter the case, or comshock, and all allure. List only	plications that caused	the death								pring	, Mary	1and 209 Approximate Interval Between	
	Physician		Immediate Cause (Final											10	Onset and De 5 years	eath
5 ()	/Medical		disease or condition resulting in death)	a. Chronic Due to (or as			3								J years	
	Examiner	_	Sequentially list conditions,	b. Hyperten												
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ience or):										
'n	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as	a consequ	uence of):										
,000	ate be nysicia ne bur	ical		d												
00 X	The law requires that the death certificate ate been signed by the attending phys age 2 should be detached for use as the	Physician/Med	IF FEMALE:	000 16 0.400												
YOU	eath c attend for us	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal	Ideath 3	∃Ectopic p ∃ Other (s							e of delive nth		ear
	the d	hysi	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	9□Unknown				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								
'n	es that gned k	by P	Part II. Other significant conditions of	contributing to death b	ut not resu	ulting in the u	nderlying	cause give	en in Part i.						ne cause of de	
ecords,	requir een si rould b	ted	Dementia					-			1 🗆	Yes 2	2⊠ No	3 ☐ Prob	ably 4 □Ur 	nknown
ב ב	elaw hasb je 2 sh	Completed									24a. Was		F	Were auto prior to co death?	psy findings a mpletion of car	vailable use of
VII	n: Th fficate or, pag	e Co	25. Was case referred to medical						OF Disco	of Dogth		2 🖾 N		Yes	2□No	
	ysicia is certi directo	To Be	examiner? 1 □ Yes 2☒ No	Hospital: 1 ☐ Inpatie	ent 2 🗆	ER/Outpatier	nt 3 🗆 D	OA Othe	er.		ne 5□ Resi		6 □Oth	er (Specif	5v)	
5	ng Ph fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		28b. Time o Injury	f	28c. Injury Work	/ at		8d. Describe				-	
200	Attending Physician: r death. ector: After this certific by the funeral director,	catic	2 Accident investigation 3 Suicide 6 Could not be		unc. At ho	mo form et	M facto		Yes 2 □		Of Logotian /	Ctroot	and Alumb	or or Pur	d Pouto Numb	nor.
$\frac{5}{5}$	l or At after o Direc J in by	Certification:	4 ☐ Homicide determined	building, et	c. (Specify	()	eet, iacto	ry, onice			City or Tol	wn, Sta	te)	er or nura	al Route Numb	Jei,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ysician: To the best niner: On the basis o												
	the Ho nin 24 the Fu	Medical	one)	and manner st		lion and/or ii				atti occuire	ed at the time,					
	vity Con	2	29b. Signature and title or confife	2//2.5	he	_	28	c. License							Day, Year)	
!	20		30. Name and address of person who	completed cause of d	leath (Item	1 23a) (Type	Print)	υ ₂	24093			J	anuar	y 4, 2		
			Mark Parkhurst, M.					er Spi	ring, N	Maryla	nd 20904	+				
	Sta		31. Date filed (Month, Day, Year) JAN 0 7 2	32 egistr	ar's Signa	ture	and the	9								
	Registr	ali	JAN U (2	JUU JUI	K L	J 40										

		For		Sta	ate of I	Marylan				alth and M	1ental F	łygier	ie		
		State Registrar					Ce	rtificate	of De	eath		Reg. N	10. 200	8	01311
Physicia	n	Decedent's Nam Sand	_	_	0.110						2. Date of Month Janua)ay 200	ar Q	3. Time of Death 5:31 P M
/Medica		4a. Facility Name (ews and numbe	9r)		4b. City, To	wn, or Loc	cation of Death	Janua		lc. County of D		J.JI I
LAGITITIC	2	20010 Wy	yman Wa	У					Germa	antown			Mont	gom	ery
Funeral Director		5. Social Security N 220-58-6		6. Sex 1 ☐ M 2		Age (In yrs. 56	last birthday, Yrs.			Under 24 Hrs. lours Min.	8. Date of (Month) May 2	Birth Day , Yea	51	Birthpla Countr	ce (State or Foreign X TN
land bw t		Usual Residence o 10a. State	f Decedent 10b. County			10c. Cit	y, Town or L	ocation						100	d. Inside City Limits
Mary a-f sh ffied a	혖	MD	Mont	gomery				Germa	ntowr	n					1 ☐ Yes 2 📉 No
with the	Dire	10e. Street and Nu 20010 Wy		У				10f. Zip C	ode	20874		_	Citizen of What		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Mari	ried 2□ Marri	12. Ware ied 1 [as Decede med Force Yes 2 Yes, Give	X No	.S. 13.	Was Deceder If Yes, specify	y Cuban, N	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or Rican, etc.)	No-	14. Race - A Black, W Specify:	hite, et	
ithin 72 houne. ne. han "naturale Medical Ex	Completed	(Spe	15. Decedent cify only highes	's Education at grade com			(Give	DO NOT use	done durir retired)	ng most of work	ing		Kind of Busine		•
lied w lygiel ther ti nt, th		12 17. Father's Name	(First Middle	i act)			Reco	very S		ALIST . Mother's Name	- (First Mid		dical I	nsu	rance
buld be f Mental I arked of atic ever	To Be	Robert 7	, , ,	Lasij					- 1	Christin			on ourname/		
ind 2 shoalth and 27 is m		19a. Informant's N Nancy L				iter				Number or Rur th Way,					
ages 1 a ant of He tr. If item y or othe			☐ Cremation		al from Sta	ite C	cemetery, cre	osition (Name matory or other 1s Cem	er place)	Janua	Date ary 8		Location - City		
permit. P Departme Importan any Injur		21. Signature of E	5 Other (S)			,	2	2. Name and	Address o	of Facility a1 Home	, 10 E	ast :	rmantow Deer Pa		
4D = 60		23a. Part1. Enter shock, or hea	the disease, or art failure. List	complication only one cau	s that cause on each	sed the deat				Gaithers	sburg,	MD	20877	1	Approximate nterval Between Onset and Death
Physician /Medical		Immediate Cause disease or condition resulting in death)	on			rator as a conseq	y Infe	ction	_						1 week
Examiner	, e	Sequentially list co	onditions,	D		nic Ob		ive Pu	1mona	ary Dise	ease				3 Years
ecuted and -transit	Examine	if any, leading to it cause. Enter Under Cause (Disease or that initiated event resulting in death)	erlying r injury s Last	c	,	as a conseq									
cate be executed physician and the burial-transit	dical E	,		d	Due to (or	as a conseq	uence or).								
ath certification or use as	Physician/Mec	IF FEMALE; 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?	1 [4 [Live birth	me pf pregna n 2 □ Feta t at time of d	al death 3	⊒Ectopic preg ⊒ Other (spec					23d. Date of Month		/ Day Year
quires that the de	2	Part II. Other signi Diabete	ificant conditions See Me11				ulting in the u	anderlying cau	se given ir	n Part I.					cause of death? bly 4 □Unknown
sician: The law requiri certificate has been si irector, page 2 should l	Completed										24a. W ai po 1∐ Ye	utopsy erformed?	prior death	to com	sy findings available pletion of cause of ! ☐ No
cian: ertifica	Be C	25. Was case refe examiner?	rred to medical							6. Place of Deat					
Physic this o	2	1 ☐ Yes 2 X		Hospita	al: 1 ∐ Inp. a. Date of I		ER/Outpatie			4 Nursing Ho			<u>`</u>	Specify)	
ding h. h. After funer	<u>i</u>	1 X Natural 2 ☐ Accident	5 ☐ Pending	g		Day Year)	Injury	M 280	lnjury at Work? 1 ☐ Yes	: 2 □ No	28a. Descri	oe now in	jury occurred		
or Atten after deat Directors in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ	ot be	e. Place of building,	injury - At ho etc. (Specif	l ome, farm, st fy)	reet, factory, o				n (Street Town, Sta	and Number or ate)	Rurai	Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Co	29a. Certifier (Check only one)	1 X Certifyin 2 Medical	Examiner: C	: To the be in the basi	s of examina	owledge, dea ation and/or i	th occurred at nvestigation, in	the time, n my opini	date and place, ion, death occur	and due to red at the tir	the cause ne, date a	(s) and manne and place, and	r as sta due to t	ted. the cause(s)
	Me	29b. Signature and	title of certifier	In	3.6	Var	rorn	29c. L	icense nu D3	umber 34386			Date signed (M anuary	_	
10		30. Name and add Carolyn	lress of per of B.	who complete	ed cause o	of death (Item	n 23a) (Type Medic	eal Cen	ter I	Drive, S	Suite	501,	Rockvi	.11e	, MD 20850
Stat Registra	е	31. Date filed (Mor		2008	32 eg	istrar's Signa		•							
		J	FII V I		# 50F (457)		ASS								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Year 07 2008 01 RICHARD LEE CHAPMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Snow Hill Worcester <u> Harrison Senior Living</u> If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sex M 2 F 8. Date of Birth (Month, Day, Year) 10/24/1915 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Virginia 92 Director 228-18-2206 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnent of Health and Mental Hyglene. and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director VA Greenbackville Accomack 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 23356 USA Funeral 2310 Captains Corridor 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by white 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 College (1-4or 5+) Agriculture Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item Z7 is marked any injury or other traumatic evone. Lola Brown Kelly Hugh Lee Chapman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2198 Spinnaker Street, Greenbackville, VA 23356 Donna Killmon (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/10/2008 4 ☐ Donation 5 ☐ Other (Specify) Union Greenbackville Cemetery Greenbackville, VA 22. Name and Address of Facility Holloway Funeral Home, Professional Association 103 Linden Ave., Pocomoke City, MD 21851 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) therosclerosis **Physician** orona /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No has e 2 r this certificate has 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 Atter thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Naturai 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

within 24 hours a 1 🚾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 054422 1-8-08 BARAL, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21851 G+. 1604 - Market 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 8 2008

BA 3

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20ď8 6 11:02 A M Willa Cromwell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1135 Ocean Parkway Ocean Pines Worcester If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 9/26/1911 1 □ M 2 🗙 F 96 NC 212-28-8791 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injuy or other traumatic event, the Medical Examination. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Directo MD Worcester Ocean Pines 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21811 USA 1135 Ocean Parkway Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X es 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wade Dolph Mary Marshall ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Canal Rd., Ocean Pines, MD 21811 Vera Mangum / sister-in-law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Cape Henlopen Crem. 1/8/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee The Burbage Funeral Home 108 William St., Berlin, MD 21811 MAH complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and only one cause on each line. Part1. Enter the disease shock, or heart failure. Approximate Interval Betw Onset and Death Immediate Cause (First disease or condition resulting in death) Physician OBSMUCTUG ruchenany Usreme /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Lige to (of as a consequence of) The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 should be 1 Pres 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page certificate 1∐ Yes 2 No or Attending Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3□ DOA 1 Inpatient 2 ☐ ER/Outpatient Certification: To this 28c. Injury at Work? filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manne of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 💋 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29c. License number 346 257 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

BA 3rl

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Erscura (MS MEPA MO (0524) 020 occamplity (Sub). Benefit MO 218//

State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Box 68760,

o

۵.

			Plea	se Type or Prin State of Ma						•		•	€.	
	•	For State Registrar					ertificat				Reg. N	200	8 0	1315
Physicia	de la	1. Decedent's Name	e (First, Middle	e, Last)						2. Date of D _ Month		av - Ye		ime of Death
/Medica	-	Wilbert								Januar				14 P M
Examine	er	4a. Facility Name (f. Holy Cro		, give street and number)					r Location of Deat Spring	ħ		c. County of E Montgot		
Funeral		5. Social Security N			e (In yrs. I	ast birthda	y) If Unde	1 Year	If Under 24 Hrs	8. Date of B	irth	T 9.	Birthplace (3	State or Foreign
Director		578-01-48	341	¹ ☑M ^{2□} F 92		Yrs	Months	Days	Hours Min.	April .	10, 1	915 D	Country)	
w w		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or	Location						10d. Ins	side City Limits
Manyli f sho	힏	DC	ĺ		Wasl	hingt	on						1 2	Yes 2 No
r 28a notif	Funeral Director	10e. Street and Nu	mber				10f. Zij	Code			10g. C	itizen of Wha	t Country?	
23a o ust be	aj	704 Miss	souri A	venue, NW			20	0011			USA			
er dea	nue	11. Marital Status	ind OF Mand	12. Was Decedent I		S. 1	3. Was Dece If Yes, spe	dent of H cify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or Noto Rican, etc.)	lo-		American Indi Vhite, etc.	ian,
Irs aft	by F	1 □ Never Marr 3 🖾 Widowed		ied 1 □ Yes 2∑ N If Yes, Give Year or Dates:	NO		1 ☐ Yes	2 X No	Specify:			Specify:	Black	:
72 hou	ted	(Spec	15. Decedent	l's Education st grade completed)		16a. De	cedent's Usu	al Occup	ation	rkina	16b.	L Kind of Busine	ess/Industry	
rithin 7 ne. han "l	Completed	Elementary/Seco		College (1-4or 5	+)			se retire	during most of wo	, rung	l Do	partme:	nt of	Navv
Hygie Hygie ther th		7th 17. Father's Name	(First Middle	Last)		Driv	/er		18. Mother's Na	me (First, Middl		*		
ld be ental ked o	To Be	Samuel (,					Wilma	P. Kenn	ey	,		
shou and M s mar tumat		19a. Informant's N	ame/Relationsl	hip (Type. Print)		i	-		and Number or R		-			
and 2 ealth an 27 is		Janis N		hter					od Place					1905
ges 1 t of H If iter or oth		20a. Method of Disp 1 ☑ Burial 2		3 □Removal from State	20b. Pi	lace of Dis emetery, c	sposition (Na crematory or	ne of other plac		Date		Location - City		ate
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 21. Signature of Fe	5 Other (S		Mar	y1ano	1 Natio		ss of Facility M	9-2008	1	rel, M		Tnc
permi Depa Impo any lo		21. Signature of Po	O Ma	ashall.					Street,					
STALLES		23a. Party. Enter t	the disease, or	complications that caused only one cause on each lir	the death	n. Do not							Appro	oximate val Between
Physician		Immediate Cause	(Final	Hypoxi									Onse	and Death
/Medical		resulting in death)	711	Due to (or as		uence of):								
Examiner	_	Sequentially list co	onditions,	b. Sinus			lia							
ted nsit	nine	if any, leading to in cause. Enter Under Cause (Disease or	injury	Due to (or as			ation							
e executed ian and urial-transit	Examiner	that initiated events resulting in death)		Due to (or as										
ficate be physicia s the bur	- 1			d. Antico	agu1	atio	n							
ertifica ing ph e as th	Physician/Medica	IF FEMALE:									3 83		-	-
eath certific attending pl for use as t	jan/	23b. Was deceden		23c. If yes, outcome	2 Fetal	death	3 ☐ Ectopic p		у		- 21	23d. Date of Month	f delivery Day	Year
the de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4∐Pregnant at 9∐Unknown	time of de	eam	5 ☐ Other (s	ecity) _						
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certific te has been signed by the attending physicial completely filled in by the funeral director, age 2 should be detached for use as the bur	by Pr	Part II. Other signi	ficant condition	ons contributing to death be	ut not resu	ılting in the	e underlying (ause giv	en in Part I.	23e. Did	I tobacco	use contribu	te to the cau	se of death?
equire en sig ould b	ed b							_		10] Yes	2 No 3 [Probably	4 ∰Unknown
has be	ompleted									24a. Wa	opsy	prio		idings available on of cause of
The ce te had	Con						,			per 1⊟ Yes	formed?		th? Yes 2□N	ło
sician certifi rector	Be	25. Was case referexaminer? 1 ☐ Yes 2 ☒		Hospital:		FD/0	OC D	Oth	26. Place of De					
y Physer this eral di	: To	1 ☐ Yes 2 ☑ 27. Manner of Deal		1x Inpatie	ry	28b. Time		28c. Inju	y at	Home 5 Re 28d. Describ			Specify)	
ath. rr: Afte	atlor	1 ⊠Natural 2 □ Accident	5 Pendin investig	gation	y Year)	Inju	y M	Wor 1 □	Yes 2 □ No					
r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could r determ				street, factor	y, office		28f. Location City or T		and Number o	or Rural Rout	te Number,
oital ours aft		00- 0-45	157 Contifuin	og Dhysician. To the heat	of multipo	wladae d	anth annurra	at the ti				(-)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)		g Physician: To the best of Examiner: On the basis of and manner sta	f examinat									ause(s)
To the compl	Me	29b. Signature and	title of certifie	r ,			29	c. Licens	e number		29d. D	ate signed (A	fonth, Day, \	(ear)
) ((Ang	1-				D005	5148		Janı	ary 1,	2008	
γ			/1	who completed cause of de						3.00	0.01	10		
		Dr. Delr						Sil	ver Spri	ng, MD	209	110		
Stat Registra	-	31. Date filed (Mor	7 2008	32. Registr	4	1000	,							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend#8_PerFHPGC1-7-08cr 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2008 2:20 Catherine Canard AM Μ. January /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing & Rehab Montgomery Rockville 8. Date of Birth 02, 1915 (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Funeral Deys Hours Months 1 ☐ M 2 🖾 F MD Director 578-01-0033 93 Usuel Residence of Deceden permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: if term 27 is marked other than "naturel", or items 23a or 28e-f show any Injury or other traumatic event. The Medical Franchise. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1⊠ Yes 2□No Funeral Director MD Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 20850 U.S.A. 299 Hurley Ave. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Status 1 ☐ Yes 2 🛛 No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ₺ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced Yeer or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Private 8 Beautician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Lest) Be Grace Rose Miller Harry O. Mills 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13403 VAndalia Dr., Rockville, MD 20853 Gladys Levy/POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 1-7-08 Brentwood, MD 22. Name end Address of Facility Ft. Lincoln F. H. 21. Signature of Funeral Service Line 144 e 3401 Bladensburg Rd., Brentwood, MD 20722 non Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician salar Accident Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as:a consequence of) Examiner led by the ettending physicien and deteched for use as the buriel-transit Hospital or Attanding Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy Completed nerformed' 1 ☐ Yes 2 No 1 ☐ Yes 2 TO No 25. Was cese referred to medical examiner? edicai Certification: To Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this eral Director: After thi filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours e To the Funeral C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00062435 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Cate Dr. Rockville, MD 20850 715 EISAYYAN Medila 9 31. Dete filed (Month, Day, Yeer, IAN 0 7 2008 32. Registrer's Signa State JAN 0 ? Registrar

			Please Type or Print in Black Inde	lible Ink. Ensure All Copies	Are Legible.
			4 101	ment of Health and Mental Hyg ficate of Death	iene _{99, No.} 2008 01317
1	Physic /Medi		Decedent's Name (First, Middle, Last)	lett 2. Date of Deat Month JANUAR U	h 3. Time of Death Day Year
	Examir Funeral Director	ier ,	Western Maryland Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey)	Colity, Town, or Location of Death Hagerstown Lunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, O8/08/19	Year) Country)
	with the Maryland a or 28e-f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locati		10d. Inside City Limits 1 Yes 2 No
	death with the Maryland me 23s or 28e-f ehow Imbal te notified at	al Director	10e. Street and Number 229 Baltimore Avenue	10f. Zip Code 21502	0g. Citizen of What Country? USA
036	or its	by Funeral	Amed Forces? If Ye	s Decedent of Hispanic Origin? (Specify Yes or Noss, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No Specify:	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036	c - 3	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kindlife. DO	's Usual Occupation d of work done during most of working NOT use retired) Dervisor	16b. Kind of Business/Industry Retail
yland ;	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other then " other treumatic event, if a Mar	To Be C	17. Father's Name (First, Middle, Last) Cecil Fern Catlet	18. Mother's Name (First, Middle, M Helen	Ayers
	1 and 2 sh Health and Iom 27 Iom other treum		Clark R. Catlett / Son 87 Mor	ningside Drive, Falling on (Name of Date	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 le any injury or other tre-		1X) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. No.	Mem. Park 01/11/2008 Memand Address of Facility Adams Famil 4 Decatur Street, Cumber	Cumberland, MD ily Funeral Home, P.A.
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. CASTROINTESTINAL resulting in death)	ne mode of dying, such as cardiac or respiratory arre	-
68760,	rate be executed whysicien and the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):		WEEKS
P.O. Box 6	death certif e attending id for use as	Physician/Medical		topic pregnancy her (specify)	23d. Date of delivery Month Day Year
	requires een signe nould be		Part II. Other significant conditions contributing to death but not resulting in the under CHRONIC OBSTRUCTIVE PULMONARY		pacco use contribute to the cause of death?
tal Rec	The lay	e Completed by	PERIPHERAL VASCULAR DISEASE 25. Was case referred to medical	24a. Was ar autops perform 1 Tyes 2	y prior to completion of cause of death? PNo 1 Yes 2 No
Division of Vital Records,	ding Phys	To B	examiner? 1	3 DOA Other: 4 🏋 Nursing Home 5 □ Reside	
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	City or Town	
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 1—Certifying Physician: To the best of my knowledge, death or (Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	igation, in my opinion, death occurred at the time, da	ate and place, and due to the cause(s)
	2 \$ 2 8 / / / A		29b. Signature and title of certifier M	1	9d. Date signed (Month, Dey, Year)

State Registrar JAN 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHUNS DALEY.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

1500 Pennsylvania Avenue Hagerstown, MD 21742

			• •	or Print in Black Ir				•	
			_ State	te of Maryland / Dep	partment of H e <i>rtificate of L</i>		, ,	0.000	01010
			Registrar 1. Decedent's Name (First, Middle, Last)		er tillicate or L		2. Date of Dea		3. Time of Death
	Physici: /Medic		Lois Mildred Cut	hbertson			Januar:	y 8, 2008	0327 ^M
	Examin		4a. Facility Name (If not institution, give street	4c. County of Death					
		36	Memorial Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Cumber1	and If Under 24 Hrs.	8. Date of Birth	Allegany	thplace (State or Foreign
	Funeral Director		218-16-4396 1□M 2		Months Days	Hours Min.	oct. 2		ryland
Т	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
of the Manual	Maryli -f sho fied at	tor	MD. Allegany	Bart	on				1 ŽॉYes 2 No
	72 hours after death with the Maryland Inatural", or Items 23a or 28a-f show dical Examiner must be notified at	Director	10e. Street and Number		10f. Zip Code 21521			10g. Citizen of What Co United Sta	
	eath w	Funeral	18913 High St.	as Decedent Ever in U.S. 13		spanic Origin? (Sr	pecify Yes or No-		
0	after de or Item niner		1 Never Married 2XMarried 1]Yes 2⊠ No	I. Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, Whit Specify: Wh	te. etc.
5-0036	ural", c	d by	3 ☐ Widowed 4 ☐ Divorced Ye	res, Give ar or Dates:	1 ☐ Yes 2 🛣 No	Specify:			
ה ה	in 72 h i "natu ledica	olete	15. Decedent's Education (Specify only highest grade comp	oleted) (Giv	edent's Usual Occupa re kind of work done o . DO NOT use retired	ation luring most of worl)	king	16b. Kind of Business Housework	-
717	filed within 7 I Hygiene. other than "r ent, the Med	Completed	Elementary/Secondary (0-12) Co unknown	illege (1-4or 5+)	memaker			nousework	
n n	be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last) Chester A. Hyde				e (First, Middle, M. Gou]	Maiden Surname)	
Maryland	2 should be n and Mental ' Is marked raumatic ev	은	19a. Informant's Name/Relationship (Type. Pr		iling Address (Street a			er, City or Town, State,	Zip Code)
	1 and 2 s Health ar tem 27 ls other trau		William P. Cuthbertso	on/husband 189	13 High St	, Barton	, Maryla	and 21521	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If the Z1 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition Y⊟Burial 2 □Cremation 3 □Remove	20b. Place of Disposer Commentery, cr	rematory or other plac		10/	20c. Location - City or Barton, Ma	
<u>=</u>	permit. Pages Department of i Important: If ite any injury or o once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Dauter n	ill Cemete		I	•	
g	perm Depa Impo any i		7. Kanu &	// . //				raı ноте rt, Marylan	d 21562
4	- 150		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. Do not e					Approximate Interval Between
	Physician	10 10	Immediate Cause (Final disease or condition resulting in death)	Polycas	toy H	Y DER	OGUST	2	Onset and Death
	/Medical Examiner			Due to (or as a consequence of):	700 8	- BUCELO		. Y	10000016
	₽ #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	1.1.70	()000	3_ <u>C</u>	<u></u>	-10 Series
	e executed ian and urial-transit	Examiner	that initiated events	Due to (or as a consequence of):					
6876U,	the death certificate be executed y the attending physician and ched for use as the bunal-transit	_	L _d	200 10 (0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					
200	death certificate be attending physici I for use as the bu	Physician/Medica	IF FEMALE.						
X R R	ath ce attendii for use	ian/	23b. was decedent pregnant		B Ectopic pregnancy			23d. Date of de Month	livery Day Year
j.	the de y the a	ysic		□Pregnant at time of death 5 □Unknown	Cother (specify)				
S, T	w requires that the d been signed by the should be detached	by Pł	Part II. Other significant conditions contributions		underlying cause give	en în Part i.		obacco use contribute t	
ord	requir een si hould b	ted l	CI GREEN	na lasons	5				robably 4 Unknown
Yec Y	has has	Completed	(a) (a) wastor	250425117		 -	24a. Was a autop perfor	prior to death?	utopsy findings available completion of cause of
	siclan: Th certificate rector, pag	Be Co	25. Was case referred to medical			26. Place of Dea		7	s 2□No
> 	Physician: this certificral director,	To B	examiner? 1 ☐ Yes No Hospita	inpatient 2 En/Outpati		4 Li Nursing n		lence 6 □Other (Spe	ecify)
	ing (fter	ion:	1)⊠ Natural 5 ☐ Pending	a. Date of Injury (Month, Day Year) 28b. Time Injury	Work	/at <br Yes 2 □ No	28d. Describe h	low injury occurred	
	al or Attending F s after death. Il Director: After d in by the funera	Certification:	a Could not be	e. Place of injury - At home, farm, s building, etc. (Specify)			28f. Location (S	Street and Number or F	lural Route Number,
2	ital or rs afte ral Dir led in	Cert	4 Homicae	building, etc. (Opecny)			City of Ton	ni, State)	
	Hosp 24 hou Fune Fely fil	Medical	(Check only 2 Medical Examiner: C	: To the best of my knowledge, dea on the basis of examination and/or and manner stated.					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Mec	29b. Signature and title of certifie	201	29c. License	e number		29d. Date signed (Mon	th, Day, Year)
)			Proser (MENO	703	31875		JANUAG	\$ 2005
		3	30. Name and address of person who complete Dr. Robert Welik, 90			l., Marvl		`	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	AP .	,, 2			
	Registr	ar	JAN 0 9 2008	James D. B.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				1 - For State Registrar		Marylar				lealth ar Death			Reg. No	L. 0	8 (8	01	319
		Physici	ian	1. Decedent's Name (First, Middle, L Joseph M. Cardu								2. Date of De Month	Da	y 004	Year	3. Time o	
		/Medi Examir		4a. Facility Name (If not institution, g		ber)		4b. City	. Town. o	r Location of I	Death	1	8	200 County of		3:35	РМ
		LXdiiii	ICI	Atlantic Genera		•			Berli					orce			
1		Funeral		Social Security Number 6.		7. Age (In yrs.	**		r 1 Year	If Under 24	Hrs.	8. Date of Bir (Month, Da 11/26/				lace (State	or Foreign
35		Director		207-26-1181 Usual Residence of Decedent	N-VIAI 5 -	75	Yrs.					11/26/	1932			P	<u> </u>
15:35		yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside C	ity Limits
		e Mar	ctor	MD Worce	ster		0cean	City								1 🗌 Yes	2 X No
120		vith th	Dire	10e. Street and Number	5				p Code					tizen of W	hat Cour	ntry?	
1		death with the Maryland me 23s or 28s-f show rmust te notified at	Funeral Director	9006 W. Biscayr	12. Was Dece	dent Ever in I	IS 13		.842	lienanie Origin	2 (Spec	ify You or No	USA	14 Race	- Americ	an Indian,	
	ယ္	or Iten	Fun	1 ☐ Never Married 2 ☑ Married	Armed For	ces? 2 □ No		_		lispanic Origir an, Mexican, F	Puerto R	ican, etc.)	,		, White,		
08	003	n 72 hours after death with the Marylar "natural", or Iteme 23a or 28a-f ehow odical Examirar must ka notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If ₹es, Give Year or Da	tes:		1 Yes	2LX No	Specify:				Specify:	Wh	ite	
00	21215-0036	n 72 h "natu edica	Completed	15. Decedent's l (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usu	al Occup	ation during most o d)	f workin	g	16b. K	ind of Bus	siness/In	dustry	
	212	1 withi	mo	Elementary/Secondary (0-12)	College (1- 4	4or 5+)		urano						Insur	rance	2	
89/8/11/000	P	al Hyg I othe vent,	BeC	17. Father's Name (First, Middle, Las	t)						Name	(First, Middle				-	
\nearrow	ya	12 should be filed within h and Mental Hygiene. 7 le marked other then " fraumatic event, the Max	To	Michael J. Card								evanny					
2	Maryland	s 1 and 2 should f Health and Men flem 27 le marke other traumatic	8	19a. Informant's Name/Relationship Eileen Carduff						and Number							
3		es 1 and 2 of Health litem 27 r other tra		20a. Method of Disposition	/ wire	20b. I	Place of Dispo cemetery, crei			yne Dr	Da	-		ocation - (
12	ē	Pages ent of nt: If i		1 ☐ Burial 2 【X Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			cemetery, crei pe Hen				/9/2	8002					
DOB: 11/26/32	Baltimore,	permit. Pages 'Depertment of H Importent: If ite any Injury or of		21. Signature of Funeral Service Lice		0	•	•		ss of Facility		Burba					
2	8	20 E # 9		MINCH!	acz	000				am St.	, be	rlin,	MD :				
				23a. Part . Enter the disease, or cor shock, or heart failure. List ont Immediate Cause (Final												Approximation of the Approxima	ween
		Physician / /Medical		disease or condition resulting in death)	a	r as a consec		Choo	wer.	eaular	1	reces			_	6	200
-		Examiner		We will be the second second	b 200 to (0	1 us u consoc	denos or,										
100		p ii	Iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury last initiated oxed)	Due to (c	r as a consec	uence of):										
1	_	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a consec	utence of):										
36	760,	ate be ex sysicien he burial	calE		4	45 4 50/1550	1001100 01).										
1	-	ntificate ng phys as the	ledic		d.										T.		
307	Box 6	The law requires that the death certifica ste has been signed by the ettending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc 1 ☐ Live bir	ome of pregna th 2 ☐ Feta]Ectopic p	regnancy					23d. Date			17
	_	ne dea the et hed fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		nt at time of d		Other (s						Mont	th	Day	Year
S\$#	P.O.	that the ed by detac	/ Ph	Part II. Other significant conditions	contributing to dea	ath but not res	ulting in the u	nderlying (ause give	en in Part I.	- 1	23e. Did t	obacco i	use contrit	oute to th	e cause of o	leath?
2	Vital Records,	quires tha n signed uld be de	ed by									10	Yes 2	□No 3	B 🗌 Prob	ably 4	Juknown
	ဝ္ပ	e law requ has been je 2 should	Completed									24a. Was		24b. W	ere auto	osy findings	available
RECH	. Ž	The I	E CO									autor perfo	osy ormed? 2 No	pr de 1 (ior to cor ath? ⊒ Yes	npletion of d 2□No	ause of
S	/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hannington .						Death (Check only o	-				
1	of	Phys this ral di	. To	1 Yes 2 The	Hospital: 1 28a. Date of		ER/Outpatien			4 🔲 Nursi		e 5 ☐ Resid				')	
4		Attending r death. ector: After by the funer	tlon	1 Natural 5 Pending 2 Accident investigate	(Month	, Day Year)	Injury	м	28c. Injury Work 1 □ '	(? Yes 2 □ No		d. Describe i	10W IIIJul	y occurre	u		
五	Division	. 6 2 3	Certification:	3 ☐ Suicide 6 ☐ Could not leadermined	28e. Place 0	of Injury - At he	ome, farm, str	eet, factor	y, office		28	f. Location (S City or Tov	Street an	d Number	r or Rura	Route Num	ber,
2		urs afte	Cer					·									
9		Hospital 24 hours a Funeral I	edical	29a. Certifier 1 ✓ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the b miner: On the bas and manne	sis of examina	wledge, death tion and/or in	occurred vestigation	at the tim , in my op	ne, date and p pinion, death	occurred	d due to the at the time,	cause(s) date and	and man I place, ar	ner as st nd due to	ated. the cause(s	;)
)		To the Hospital of within 24 hours at To the Funeral D completely filled in	Med	29b. Signature and title of certifier	with the diffe			29	c. License	number			29d. Dai	e signed	(Month,	Day, Year)	
				V/ The	Ke	(I)2	876	9		ı	19	los	3	
		22.11		30. Name and address of person who	completed cause	of death (Item	n 23a) (Type,	Print)	1	11	1/ /	,		, ,	Ti,	3 IPC	
	1	3A 4	• 0	31. Date filed (Month, Day, Year)	22 Pa	gistrar's Signa	D /2	07	wa	TREA 1	regh	wy	tu	ruc c	ple	in	(274
		Sta Registr		IAN 0 9 2	กกล	gioriai a Oigila	H A	made.	,		•	,					

Certificate of Death

2. Date of Death Month

Day

Year

Somerset

USA

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Month

Specify.

14. Race - American Indian, Black, White, etc.

White

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Year) JAN 0 32. Registrar's Signature

1. Decedent's Name (First, Middle, Last)

WILLIAM

CARMINE

JESSE

Physician

3:55 A M

10d. Inside City Limits

1 X Yes 2 No

R	legis	traı

31. Date filed (Month, Day,

Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, Maryland 21817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Fannie Delzie Collot 3:15p 01 03 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Pines Genesis HealthCare
is Social Security Number 6. Sex J. Age (In yrs. last bi Easton Talbot 8. Date of Birth (Month, Day, Year) Jan. 31, 1917 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Tennessee 90 413.18.1297 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location id 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 is marked other than "natural", or Iteme 23a or 28a-f show traumatic event, the Medical Examinet must be notified at 10d. Inside City Limits Maryland Talbot Easton 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29562 Charles Drive 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Bfack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married blot, Delzie Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Retail permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event SDE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Malcolm Callahan Martha Graham ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Nagle/Daughter 29562 Charles Dr., Easton, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ØBurial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paran Cemetery Jan. 5, 2008 Overton County, TN Signature of Funeral Service Licensee Girran-Fromwell Funeral Hope 15308 High St., Cambridge, MD 21613 3a. Part 1. Enter the disease, or complete fins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 heuner's dementin Physician Means /Medical Due to (or as a consequence of). Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physicien and s the burial-transit resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of daath? adult-type 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown eoporosts 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? res 22 No his certificate h I director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After the completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael Crowley 610 Dutchman's Lane Easton, MD 21601 31. Date filed (Month, Day Year) 32. Restrar's Signature State Registrar

Collot

P.O. Box 68760.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** PM 2008 Koscoe January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 99A Whiteleysburg Greensboro aroline 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Aug 31 9. Birthplace (State or Foreign Country) Delaware Age (In yrs. last birthday, **Funeral** Months 1 M 2 F Days 219-60-1342 55 1952 Aug Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Caroline Maryland Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 99 A Whiteleysburg Road 21639 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event than "natural", or iten Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
disabled Elementary/Secondary (0-12) College (1-4or 5+) N/A 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John F. Clough Hilda E. Cahall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnne Lister/ PO box 688; Greensboro, Maryland 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHesapeake Crm Cn CHester, Maryland 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home PA Flees 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO box 160; Greensboro, Maryland Immediate Cause (Final **Physician** obstructive disease or condition resulting in death) hrenic Dulmonary /Medical Due to (or as a consequence of): Examiner Structive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed · mor bid Ohes Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ congestive heart failure, diabetes, 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed tobacco use Chronic low back 1∐ Yes 2 ₩No phronic or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Funeral 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 one)

State Registrar

29b, Signature and title of certifier

31. Date filed (Month, Day, Year)

J. KARNES-

JAN

PATRICIA

30. Name and adoress of person who completed cause of death (Item 23a) (Type, Print)

2008

AMZIBEL

32. Registrar's Signature

DHMH 17 Rev 1/2001

316 Railroad Avenue

29c. License number

P.O. Box 122

29d. Date signed (Month. Dav. Year)

Goldsboro, MD 2163

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State Registrar Ce	ertificate of Death	R	eg. No.	01323							
%	Physici	an	1. Decedent's Name (First, Middle, Last) Agnes Geraldine Carr		2. Date of Deat	16 2008	3. Time of Death 9:30 A M							
	/Medic Examir		4a. Facility Name (If not institution, give street and number))	4c. County of Dea									
			Washington County Hospital Hagerstown Washi											
e e e e e e e e e e e e e e e e e e e	Funeral Director		5. Social Security Number 6. Sex 1 M 2 MF 7. Age (In yrs. last birthda 82 Yrs. Usual Residence of Decedent	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Apr 23,	9. Bir 1925	thplace (State or Foreign ountry) PA							
	/land ow at		10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits							
	e Mar ta-f sh tified	ctor	MD Washington Hag	erstown			1X Yes 2 No							
	th with th	al Dire	10e. Street and Number 333 Hill Street	10f. Zip Code 21742	1	l0g. Citizen of What C	A							
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi								
2	"natu	etec	(Specify only highest grade completed) (Giv	edent's Usual Occupation we kind of work done during most of work		16b. Kind of Business	/Industry							
121	within ene. than the Me	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Grocery	store							
שכ	other other	Be C	17. Father's Name (First, Middle, Last)		, ,	Maiden Surname)								
ylar	Menta Menta arked atlc e	To E	Bennard Gates	Minni	e Rebecca	a Creager								
, Maryland 21215-0036	and 2 sho salth and n 27 Is m er traum			lling Address (Street and Number or Ru 5 Grandview Ct.,		-								
Baltimore,	Pages 1 ment of He ant: If Iten ury or oth		1 ☐ Burial 2 ☒ Cremation 3 ☒ Removal from State Cumber 1 4 ☐ Donation 5 ☐ Other (Specify) Cremato	LIGHT	21,2008 V	20c. Location - City o Vaynesboro	, PA 17268							
pall	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	22. Name and Address of Facility $Group Group										
08700,	Physician process of a physician and as the burial-fransit as the burial-fransit	Completed by Physician/Medical Examiner	ledical Exam	ical Examiner	ical Examiner	cal Examiner	cal Examiner	Exam	Exam	Sequentially list conditions, if any, leading to Immediate Due to (or as a consequence of):	umon, e	u s		
P.O. BOX 68	The law requires that the death certifica to has been signed by the attending phoage 2 should be detached for use as it				B⊟Ectopic pregnancy □ Other (specify)		23d. Date of de Month	elivery Day Year						
as, r.	uires that i signed by Id be deta		Part II. Other significant conditions contributing to death but not resulting in the \mathfrak{I}	underlying cause given in Part I.		bacco use contribute fes 2 □ No 3 □ F	to the cause of death?							
Division or vital Records,	The la ate has page 2		Complete			24a. Was a autops perfor 1∐ Yes	sy prior to							
VII.	Physician: r this certific ral director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2☐ No Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	Other:	ath (Check only or									
on or	> .02 D	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at		ence 6 ☐Other (Sp ow injury occurred	ecity)							
DIVIS	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,							
	Hospi 14 hour Funer. Tely fills		29a. Certifier (Check only (Ch	ath occurred at the time, date and placinvestigation, in my opinion, death occ	e, and due to the durred at the time, d	cause(s) and manner a	as stated. ue to the cause(s)							
	o the ithin 2 o the l	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mor	nth, Day, Year)							
)	F ≥ F 8		m	006039		1/16	(08							
			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) 11 2 G	exstow.	ct mn	21740							
×c	Sta Regist	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	all s										

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

29b. Signature and title of certifier

31. Date filed (Month Day, Year)

Kanjilla 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

NAGARATNAM RANJITHAN, ND.

29c. License number 0 1 9 3 18

29d. Date signed (Month, Day, Year)

SIT OIDTOWN RD, CUMBERLAND, MD 21502

08-00272 James Crislip Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1-For State amend #5 Per INF G879 5 6 5 10 10 10 10 10 10 10 10 10 10 10 10 10	Ju Death	Reg. No.	2000 0132
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	Year 0610 hrs
wedicai Exami	ner	JAMES EARLE CRISLIP 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month Day January 10, 2008	8 Oo TO FIFS County of Death
		Johns Hopkins Bayview Medical Center	Baltimore	40.	County of Death
Funeral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. 8. Date of Birth (MM/D	DD/YYYY) 9. Birthplace (State or Foreign
Director		178-32 -3615 1X M 2 F 66	Yrs. Months Days Hours Mir	09-06-1941	Country) PENNSYLVANIA
		Usual Residence of Decedent		103 00 1341	
w any		10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City Limits 1 X Yes 2 No
/aryland 28a-f show 1 at once,	tor	WV MONONGALIA MORGANT 10e. Street and Number	OWN 10f. Zip Code	I 40a Citiza	en of What Country?
ith the Maryland 23a or 28a-f sho notified at once.	Director	352 PIXLAR HILL ROAD	26508		
15-0036 filed within 72 hours after death with the Maryland Hygiene. ed other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once			Was Decedent of Hispanic Origin? (S	US pecify Yes or No- 1	14. Race - American Indian, Black,
death or iten nust b	Funeral	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
after	by F	or Dates:	Yes 2X No specify:		Specify: WHITE
hours af "natural			dent's Usual Occupation (Give kind of g most of working life. DO NOT use ret		nd of Business/Industry
36 hin 72 e. than	Completed		ARDOUS WASTE ESCO	er (o s r)	ESCORTING
5-0C ed wit tygien other the M	S	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden S	
O 2 2 4 2 1	Be	HARRY CRISLIP	RUTH WI		
ID 21 Should I and Mer 27 is mar matic ev	٤	Martha	iling Address (Street and Number or		
md 2	-		BANBURY PL., HOUST		027 ocation - City or Town, State
TOFE ages 1 at of H t: If i		TATTI MEM	rother place)		
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		1 12 Deliation of Total Opening.	2 Name and Address of Facility		DRGANTOWN WV
Dep Dem	И	Robert 1 Boleand	· WV	YU HUMAN GIF DRGANTOWN, W	T REGISTRY V 26506
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest, shoo	ck, or heart Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular I	Disease		Death
		or condition resulting in death) Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	Examiner	Colsease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
760, Teate be executed physician and the burial - transit		dd.		6	
e exection a	Medical	UNPENDED X AMENDED	.G882.8/11/08.WS		
760 Teate b		IF FEMALE: 23c. If yes, outcome of pregnancy	m-		. Date of delivery
Box 687 death certifine.	cian	past 12 months? 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic pregna Other (Specify)	ancy I	Month Day Year
Boy e death the att	Physician	1 Yes 2 No 9 Unknown g Unknown	Ottlei (Opcony)	-	
P.O. Box 68 so that the death certification of the attending endetached for use as		Part II. Other significant conditions contributing to death but not resulting in t	ne underlying cause given in Part I.		se contribute to the cause of death?
S, P.C puires that on signed and be deta	Completed by	Diabetes mellitus			No 3 Probably 4 Unknown
cords, law requires been seen seen seen seen seen seen se	ped			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Rec The l	5			1 Yes 2 ✔ No	
Vital Rec hysician: The this certificate I director, page	Be	25. Was case referred to medical examiner? Hospital:	26.Place of Death (Check ent 3 DOA Other Nursin		
n of V ding Phys 1. After thi funeral di	은	1 ✓ Yes 2 No Parameter 2 ✓ Live Supplies 27. Manner of Death 28a. Date of Injury 28b. Time		ng Home 5 Residen 28d. Describe how injur	
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been steel in by the funeral director, page 2 should t	ţį	1 V Natural 5 Pending (Month, Day,Year)	1 Yes 2 No		
Visi or Att fter de Directe	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.		d Number or Rural Route Number, City
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and rety filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	4 Homicide determined (Specify)		or Town, State)	
Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death or (Check only one) Wedical Examiner: On the basis of examination and/or invest			
To the within 7 To the complet	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
			O.C.M.E.		ary 10, 2008
OCME	}	30. Name and address of person who completed cause of death (Item 23a)			
		Mary G. Ripple MD. Deputy Chief Medical Examiner	111 Penn Street, Baltimore, N	MD 21201	
		31. Date filed (Month, Day, Year) 32. Registrar's Signature	£ 2		
Regist		JAN 2 2 2008 AS Seven AF LOON			

			For State	State of Marylan	•	rtment of H tificate of I			-	
18		VIII	Registrar 1. Decedent's Name (First, Middle, Las	st)	Cei		Jean	2. Date of Dea		3. Time of Death
	Physicia		Jam	es Everett Dav	ris			January	13 2008	0140 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	<u>-</u>	4c. County of Dea	ath
, de			Union Hospital			E1kton	If I lodge 0.4 Uro	0.0.4. (8:4	Cecil Cecil	
	Funeral		5. Social Security Number 6. S	MM 2DE	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y, <i>Year</i>) 9. Bi	rthplace (State or Foreign Country)
	Director		234-40-6354 Usual Residence of Decedent	80				JAN 15	, 1927 Wes	st Virginia
	nylanc how at		10a. State 10b. County	10c. City	y, Town or Loc	cation		·		10d. Inside City Limits
	e Ma Ba-f s	cto	Maryland Cecil	E	Elkton					1 X Yes 2 □ No
	with the	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
	eath v	era	150 East Main St	reet 12. Was Decedent Ever in U.	S 13 V	21921	ispanic Origin? (Sp	ecify Yes or No	United 14. Race - Am	
^	r Item	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? Wor	Tra		ispanic Origin? (Sp in, Mexican, Puerto	Rican, etc.)	Black, Wh	
2-003p	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show dical Examiner must be notified at	by	3 ☐ Widowed 4 X Divorced	If Yes, Give War Year or Dates: Kor	rea	□Yes 2X No	Specify:		Specify: W	hite
ر م	72 hc 'natu dical	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Deced (Give	ent's Usual Occup- kind of work done o	ation during most of work l)	ing	16b. Kind of Busines	s/Industry
N	within iene. than " the Mec	du	Elementary/Secondary (0-12)	College (1-4or 5+)		er/Operat			Tree Se	rvico
D	filed Hygid Sther ent, th	ပ္မ	17. Father's Name (First, Middle, Last)		OWII	er/Opera		e (First, Middle,	Maiden Surname)	1 1106
au	lid be lental rked c	To Be	William Christop	her Davis			Kate S	nvder		
ary	12 should be filed wan and Mental Hygie Is marked other the raumatic event, the		19a. Informant's Name/Relationship (19b. Mailin	g Address (Street			er, City or Town, State,	Zip Code)
e, ≥	and 2 ealth n 27 i		Evelyn D. Doning				eet, Beck			
	Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. snt; If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 XC Cremation 3 ☐	Hemovai from State		sition (Name of natory or other place	Juliuc	oate ary 14,	20c. Location - City of	
бащтог	it. Pag rtment rtant; I njury o		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer			& Co., Inc.			West Ches	ster, PA
n D	permit. Pag Department Important: Ii any injury o		21, Signature of Fulleral Service Licer	0 4:00	Η̈́i	cks Home	for Fune	rals, P	A.MD 2192	1
V.	2019		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Pman 114	+ (0)					Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):					
	Examiner	_	Sequentially list conditions,	b. COPI)					
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence or):	0.				
7	al-trai	Exar	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):	_ نائل				
00/00	fficate be executed y physician and is the burial-transit	edical	(d. 7x	of (R Mp				
	ng ph	Medi	IF FEMALE:							
Š D	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta	ıl death 3 □	Ectopic pregnancy	,		23d. Date of d Month	elivery Day Year
5	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of d 9□Unknown	leath 5∟	Other (specify)				
ŗ.	that the		Part II. Other significant conditions of	ontributing to death but not res	ulting in the un	derlying cause give	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
vital Records,	quires an sign	ed by						1 🗆 '	Yes 2 No 3 □ I	Probably 4 □Unknown
) (၁	law re	plet						24a. Was	an 24b. Were	autopsy findings available completion of cause of
Ē	The ate his page	Completed							rmed? death?	?
	iclan: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat	h <i>(Check only</i> c	one)	
0	Physic this cral dire	- T	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 ☐	ER/Outpatient		4 □ Nursing Ho		dence 6 Other (Sp	pecify)
	th. : After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injur Worl M 1 □	k? No Pes 2 No	Edd. Dooring 1	now injury occurred	
VISION	Atter r deal ector by the	ifica	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specif	l ome, farm, stre	eet, factory, office		28f. Location (3	Street and Number or I	Rural Route Number,
5	tal or rs afte all Dir	Certification:		Building, etc. (opecn)				Only or To	vii, Gtate)	
	To the Hospital or Attending Physician: The law requires that the death certifully a thours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		ysician: To the best of my kno niner: On the basis of examina and manner stated,						
	To the within Fo the comple	Mec	29b. Signature and title of certifier	and marrier stated.		29c. License	e number		29d. Date signed (Mo	nth, Day, Year)
;			Dui ce Ha	-MD		Do	4823		1/14/0	18
	4+1		30. Name and address of person who JUI CHH HKU	completed cause of death (Item	n 23a) (Type, I	et Mu	4823 u st	EllChon	Md	21921
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature					у
	Registr	ar	1011 0 9 20	108	The Asia	A Second				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:15 PM anuary 14, 2008 Blain Marjorie Dunn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham er 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F 90 Director 426-16-1199 June 12,1917 Mississippi Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Calvert Owings 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20736 1390 W. Mt. Harmony Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No þ Specify: white 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) education 4 teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blain Weatherall ٩ Homer Georgia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ,1 and 2 s of Health a Thomas N. Dunn, son 1390 W. Mt. Harmony Road, Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan Crematory 01-15-08 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21: Signature of Funeral Service License 8325 Mt. Harmony Lane, Owings, MD 20736 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. List only one cause in each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the di e shock, or heart falur Immediate Cause (Final PTIC Physician wK resulting in death) /Medical Due to (or is a consequence of): Bowel disease Examiner schemic organization is conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last intestinalis Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical as the I IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes performed' 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: To the Funeral Director: completely filled in by the within 24 hours a To the Funeral I

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

FARHAD

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

32. Registrar's Signature

JAMALI

Year)

29c. License number

7525 Greenway Center Dr. Greenkelt MD 20710

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 1sanuary 03, 2008 Mary Sue Driskill 4c. County of Death /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner harles Plate Year | If Under 24 Hrs. enter Medica Social Security Number 9. Birthplace (State or Foreign Country) Pittsylvania Cty, Age (In yrs. last birthday) Year) Months Days Hours **Funeral** 1 ☐ M 2 🖸 F 26, 1916 Aug 226-09-2682 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylant Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Owings Director Calvert Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20736 1041 Concord Court 14. Race - American Indian Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Black. White. etc. 11. Marital Status Specify: White 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4or 5+) Drug Store Clerk 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Sue Pillar George Wooding Saunders 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20736 1041 Concord Court, Owings, MD William A. Driskill - Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Adelphi, Maryland George Washington Cemetery 1/8/2008 4 □ Donation 5 □ Other (Specify) 4739 Baltimore Ave. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gasch's Funeral Home, P.A. Hyattsville, MD 20781 MOINGI wohill 23. Part1. Enter the disease, or omplication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List orly one cause on each line. Approximate Interval Between Onset and Death LOUI S Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of) /Medical Years **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last and Due to (or as e consequence of) physician and the purial-t P.O. Box 68760. Physician/Medical ast 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery IF FEMALE: use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Vear Por in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. recurrent UTI'S 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division or Vital Records, ş Injufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) examiner? 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mariner of Death funeral Certification: Injury Natural 5 ☐ Pending investigation To the Hospital or Attending 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3□ Suicide 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hours a

To the Funeral I

completely filled 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier Indum 61614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 304 Wolderf Ravinder K. Sindhwani Mp 11350 Pembrock Sa

State Registrar 31. Date filed (Month, JAN 0 7

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** Veronica 11:35 AM Helen Depew January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany WMHS-Braddock Campus Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 □ M 2 K F 76 198-24-1215 Director 04/28/1931 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 No WIN Director Mineral Ridgeley 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Route 4 Box 165 26753 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 3 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Frank Steffan Helen Ann Jasko 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon A. Caldwell / Daughter Route 2 Box 138, Ridgeley, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 01/08/2008 | Cumberland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Lipenses 404 Decatur Street, Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final reaus **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying table plocate or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-transi and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day 4 ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HIN 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑No 24a. Was an has autopsy performed certificate ! 1☐ Yes Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA this funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗀 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ce D46346 January 8, 2008 Ma un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD 21502 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 0 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Nina Miller Delaney 2:40 2008 January 1, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 1966). 2 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Days Months Hours Min 1 M 2 X 229-16-0525 90 Feb. 1917 Virginia Director Usual Residence of Decedent 10d. inside City Limits 10c. City, Town or Location 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Maryland Annapolis 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21401 604 Dubois Court U.S.A. by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23 any Injury or other traumatic event, the Medical Examiner must 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Roland Miller Lavinia Waring ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Benjamin Delaney, Jr./son 604 Dubois Court Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore Crematory 1/3/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice License 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed

after death.

Director: A
d in by the fu

Division or Vital Records, P.O. Box 68760,

cal Examiner	Sequentially list conditions, leading to immicause. Enter Unueri Cause (Disease or in that initiated events resulting in death) La	nediate ying ijury
ication: To Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 9 ☐ Unknown	No
ompleted by F	Chroni	
To Be C	25. Was case referred examiner?	
ation:	27. Manner of Death Natural 2 Accident	5 ☐ Pendinves

23d. Date of deliv	very Day Yea
	23d. Date of deliver Month

23e. Did tobacco use contribute to the cause of death? itions contributing to death but not resulting in the underlying cause given in Part I. 1 Tyes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Ves 212 No death? 1 ☐ Yes 2□ No cal 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) ding stigation 1 Tyes 2 □ No ld not be Piace of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ermined 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical

29a. Certifier

29b. Signature and title of certifier

ho completed cause of death (Item 23a) (Type, Pnnt)

Defense they, Crofton, mo 21114 2225EL Pav 31. Date filed (Month, Day, Year)

State Registrar 3 0 MAL



within 24 hours af To the Funeral D completely filled in

ш	ă
Name and Address of the Owner, where	PI E
.O. Box 68760,	of or Attending Physician: The law requires that the death certificate be executed
Records, P	The law requires that
Division or Vital Records, P.O. Box 68760,	or Attending Physician.
_	6

To Be Completed by Funeral Director	12-01-8905	Pet 2 Was Decedent Every Armed Forces? 1 Yes, Give Year or Dates: ation completed) College (1-4or 5+) Step	Delman ver in U.S. hens	thday) Yrs. In or Location 13. Wat- If Y. 1 C. Deceden (Give kin life. DO	to City, Town, or funder 1 Year fonths Days 10f. Zip Code 2187. s Decedent of Hies, specify Cuba	spanic Origin? (Sp nn, Mexican, Puerlo Specify: ation during most of work))	ecify Yes or No Rican, etc.)	Day 05 4c. Count 1, Year) 1919 10g. Citizen of	Tour Dela	place (State or Finity) NWATE 10d. Inside City Yes 2 Intry? Ican Indian, , etc.	
To Be Completed by Funeral Director	Social Security Number 12-01-8905 1	Pet 2 Was Decedent Every Armed Forces? 1 Yes, Give Year or Dates: ation completed) College (1-4or 5+) Step	88 10c. City, Town Delman ver in U.S. 16a.	thday) Yrs. In or Location 13. Wat- If Y. 1 C. Deceden (Give kin life. DO	f Under 1 Year flonths Days 10f. Zip Code 2187. s Decedent of Hies, specify Cuba 1 Yes 2 No ht's Usual Occupid of work done of NOT use retired	Isbury If Under 24 Ars. Hours Min. 5 spanic Origin? (Sp. Mexican, Puerto Specify: ation furing most of work	ecify Yes or No-Rican, etc.)	10g. Citizen of USA 14. Re Bl Spec	9. Birth Cou De la f What Cou	place (State or Finity) NWATE 10d. Inside City Yes 2 Intry? Ican Indian, , etc.	
To Be Completed by Funeral Director	Social Security Number 12-01-8905 Sual Residence of Decedent	2. Was Decedent Evarmed Forces? 1 □ Yes, Give Year or Dates: ution completed) College (1-4or 5+) Step	88 10c. City, Town Delman ver in U.S. 16a.	n or Locati	ion 10f. Zip Code 2187. s Decedent of Hi es, specify Cuba Yes 2K No nt's Usual Occupid of work done of NOT use retired	5 spanic Origin? (Spenic Appendix Appen	ecify Yes or No-Rican, etc.)	10g. Citizen of USA 14. Ri Bl Spec	9. Birth Cou Dela I What Cou	place (State or F ntry) NWATE 10d. Inside City NY Yes 2 Intry? Ican Indian, , etc.	
To Be Completed by Funeral Director	12-01-8905 Sual Residence of Decedent Oa. State	et 2. Was Decedent Event Armed Forces? 1	88 10c. City, Town Delman ver in U.S. 16a.	Yrs. Man or Location or Locati	10f. Zip Code 2187. s Decedent of Hi es, specify Cuba I Yes 2 N No nt's Usual Occupind of work done of NOT use retired	5 spanic Origin? (Sp n, Mexican, Pueric Specify: ation during most of work	ecify Yes or No-Rican, etc.)	10g. Citizen of USA 14. Ra Bl Spec	Dela What Cou ace - Ameriack, White What Business/In	Iware 10d. Inside City 1\text{1\text{Y}} Yes 2 Intry? Ican Indian, , etc.	
To Be Completed by Funeral Director	Oa. State MD Wicomico Oe. Street and Number 605 E. Walnut Street 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grade of States) Elementary/Secondary (0-12) 11 7. Father's Name (First, Middle, Last) Luther 19a. Informant's Name/Relationship (Type Alfred Davis — Husi Oa. Method of Disposition 1 Marital 2 Cremation 3 Rei	et 2. Was Decedent Ev. Armed Forces? 1 □ Yes 2 □ No. If Yes, Give Year or Dates: ation completed) College (1-4or 5+) Step	Delman verin U.S.	13. War If Y	10f. Zip Code 2187. s Decedent of Hi es, specify Cuba] Yes 2 No nt's Usual Occupad of work done of NOT use retired	spanic Origin? (Sp nn, Mexican, Puerlo Specify: ation during most of work))	ecify Yes or No Rican, etc.)	USA 14. Ra Bl Spec	f What Cou ace - Ameri ack, White ify: Wh:	1X Yes 2 intry? ican Indian, , etc.	
To Be Completed by Funeral Director	MD Wicomico Oe. Street and Number 605 E. Walnut Street 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grade of Specify highest grade of Specify only highest grade of Specify highest gra	et 2. Was Decedent Ev. Armed Forces? 1 □ Yes 2 □ No. If Yes, Give Year or Dates: ation completed) College (1-4or 5+) Step	Delman verin U.S.	13. War If Y	10f. Zip Code 2187. s Decedent of Hi es, specify Cuba] Yes 2 No nt's Usual Occupad of work done of NOT use retired	spanic Origin? (Sp nn, Mexican, Puerlo Specify: ation during most of work))	ecify Yes or No Rican, etc.)	USA 14. Ra Bl Spec	ace - Ameri ack, White ify: White Business/II	intry? ican Indian, , etc.	
To Be Completed by	0e. Street and Number 605 E. Walnut Street 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of Specify only highest	2. Was Decedent Evanmed Forces? 1	ver in U.S.	13. Was If You	2187 s Decedent of Hi res, specify Cuba Yes 2 No nt's Usual Occupid of work done of NOT use retired	spanic Origin? (Sp nn, Mexican, Puerlo Specify: ation during most of work))	ecify Yes or No Rican, etc.)	USA 14. Ra Bl Spec	ace - Ameri ack, White ify: White Business/II	ican Indian, , etc. ite	
To Be Completed by	1. Marital Status 1	2. Was Decedent Evanmed Forces? 1	hens	1 C Deceden (Give kin life. DO	s Decedent of Hi es, specify Cuba Yes 2X No "t's Usual Occupated of work done of NOT use retired	spanic Origin? (Sp nn, Mexican, Puerlo Specify: ation during most of work))		14. Ra Bl Spec 16b. Kind of	ack, White ify: Wh: Business/Ir	etc. ite	
To Be Completed by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of 11 7. Father's Name (First, Middle, Last) Luther 19a. Informant's Name/Relationship (Type Alfred Davis — Hus) 10a. Method of Disposition 1 Marrial 2 Cremation 3 Rei	Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Attion Completed) College (1-4or 5+) Step e. Print)	hens	1 C Deceden (Give kin life. DO	Yes 2 No 't's Usual Occuping of work done of NOT use retired	Specify: ation during most of work)		Speci 16b. Kind of	ack, White ify: Wh: Business/Ir	etc. ite	
To Be Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa (Specify only highest grade of 1.1 only highest grade of 1.2 only highest	rryes, Give Year or Dates: ation completed) College (1-4or 5+) Step e. Print)	hens	. Deceden (Give kin life. DO	nt's Usual Occupa nd of work done of NOT use retired	ation during most of work i)	ing	16b. Kind of	W11. Business/Ir		
To Be Completed	(Specify only highest grade of Elementary/Secondary (0-12) 1 1 7. Father's Name (First, Middle, Last) Luther 19a. Informant's Name/Relationship (Type Alfred Davis — Hus] 20a. Method of Disposition 1 \$\mathbb{Y}\$ Burial 2 \$\mathbb{C}\$ Cremation 3 \$\mathbb{C}\$ Relationship (First, Middle, Last)	College (1-4or 5+ Step 9. Print)	hens	(Give kin life. DO	nd of work done o NOT use retired	during most of work	ing			ndustry	
To Be	Elementary/Secondary (0-12) 11 7. Father's Name (First, Middle, Last) Luther 19a. Informant's Name/Relationship (Type Alfred Davis — Hus 10a. Method of Disposition 1 \(\mathbb{N} \) Burial 2 \(\mathbb{C} \) Cremation 3 \(\mathbb{R} \) Ret	College (1-4or 5+ Step	hens	life. DO	NOT use retired			Own H	ome		
To Be	7. Father's Name (First, Middle, Last) Luther 19a. Informant's Name/Relationship (Type Alfred Davis — Hus 10a. Method of Disposition 1 \$\mathbb{X}\$ Burial 2 \$\mathbb{C}\$ Cremation 3 \$\mathbb{C}\$ Ret	e. Print)		пош	lemaker			OWILLI	Ome		
P _	Alfred Davis - Hus Oa. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rei	e. Print)				18. Mother's Nam	e (First, Middle,	Maiden Surna	ame)		
	Alfred Davis - Husl Oa. Method of Disposition 1 \(\) Burial 2 \(\) Cremation 3 \(\) Rei		10h			Pear1		Beds	worth		
	20a. Method of Disposition 1 XI Burial 2 ☐ Cremation 3 ☐ Rei	band				and Number or Ru					
2	1 X Burial 2 ☐ Cremation 3 ☐ Rei		20b. Place o			Street,	Delmar,	Maryl 20c. Location			
	4 ☐Donation 5 ☐ Other (Specify)	moval from State	cemete	ry, crema	tory or other plac	i i			·		
2	21. Signature of Fuperal Service Licensee	01/	Wango	Ceme 22. N	etery Name and Addres	ss of Facility Box	-2008	Wango,		Tanu	
	Melisse Hewy	Blake	e	705	E. Mai	n Street	, Salist	oury, M	ary1a	nd 2180	
1	23a. Part1. Enter the disease, or care lica shock, or heart failure. List poly one	e cause on each line	€.	not enter	the mode of dyin					Approximate Interval Betwonset and De	
	Immediate Cause (Final disease or condition resulting in death)		umo		A					DAY	
	resulting in doctor)	Due to (or as a	consequence	of):							
je i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence	of):							
툂	that initiated events c										
gici	d.		_								
	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome p		h a∏E	ctopic pregnancy	4			Date of deli		
sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Pregnant at t			Other (specify)				Month	Day Y	
	9 ☐ Unknown Part II. Other significant conditions cont	tributing to death bu	t not resulting	in the und	erlying cause giv	en in Part I.	23e. Did	tobacco use co	ontribute to	the cause of de	
b o							1 🗆	Yes 2□ No	3 □ Pr	obably 4 5 d	
Completed							24a. Was		b. Were au	itopsy findings a	
mo							auto perfi 1∐ Yes	ormed?	death? 1 ☐ Yes	completion of ca 2 □ No	
	25. Was case referred to medical examiner?	annital:			104	26. Place of Dea					
은	1 ☐ Yes 2 ☐ No ☐ HG 27. Manne f Death	ospital: 1 Inpatier 28a. Date of Injury		utpatient Time of	3 DOA Oth	ner: 4 Nursing H	ome 5 Res			cify)	
tion	1 L atural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	Woi	rk?ື Yes 2 □ No	2001 20001100				
ifica	3 Suicide 6 Could not be determined	28e. Place of inju- building, etc	ry - At home, f	arm, stree	et, factory, office		28f. Location	(Street and Nu	mber or Ru	ural Route Numl	
Certification:											
	29a. Certifier 1 ertifying Physic (Check only one) 2 Medical Examin	er: On the basis of	examination a								
Med -	29b. Signature and title of certifier	and manner sta	tea.		29c. Licens	se number		29d. Date sig	ned (Mont	h, Day, Year)	
	> Syrin -	s mo			0	0062916		JANU	INRY	6,20	
	30. Name and address of person who cor	mpleted cause of de	eath (Item 23a)) (Type, P	rint)	UTTE B					

			For State	State o	f Marylan		rtment <i>tificate</i>		ealth and N		- 1	2008	01332
			Registrar	2061			inicate	OIL		2. Date of Dea	leg. No.⊆		3. Time of Death
	Physicia	-	Decedent's Name (First, Middle, La John		ustin		Davi	s		Month Januar	Day	Year 2008	10:55 P ^M
	/Medic Examin	de A	4a. Facility Name (If not institution, gi	ve street and nu	mber)	~	4b. City, 7	Town, or	Location of Death			County of Death	
			Beverly Living	Ctr. of	Cumberl	Land		Cuml	berland			Allegar	ıy
	Funeral		Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)	If Under	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	n /. Year)	9. Birthp	lace (State or Foreign
	Director		213-24-6845	1 X M 2 □ F	80	Yrs.	WOTHING	Duyo	110013 111111	12/13/			land
	p _		Usual Residence of Decedent		140- 0:6	y, Town or Lo						1.	0d. Inside City Limits
	arylan show d at	_	10a. State 10b. County Alle		100. Cit	•							1 ☑ Yes 2 ☐ No
	Ba-f	5		gany ————			berla						
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number 53 Cresap St	reet			10f. Zip		502		10g. Citiz	en of What Cour USA	try?
	ems 2	ner	11. Marital Status	Armed Fo	edent Ever in U	.S. 13. \	Was Deced If Yes, spec	ent of Hi	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- Rican, etc.)	1	4. Race - Americ Black, White,	
20	rs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 【X Widowed 4 ☐ Divorced	1 X Yes If Yes, Gi Year or D	2□No 192 ive Dates: 192	16-	1 ☐ Yes 2		Specify:			Specify:	+ ~
-0030	2 hou	pe	15. Decedent's E	Education		16a. Deced	dent's Usua	l Occupa	ation		16b. Kin	Whi of Business/Ind	
<u> </u>	hin 72 in "ni Medi	Completed	(Specify only highest g	rade completed) College ((Give life, L	kind of wor DO NOT us	k done d e retired	during most of wor)	king			
7	d with	E O	12				Lat	ore	r		Tire	and Rub	ber
and	othe /ent,	Be C	17. Father's Name (First, Middle, Las	it)					18. Mother's Nam			· ·	
yıar	ould by Menta arked atlc et	To E		Austin		Davis			Edna		ina		hell ——————
Mar	d2sh thand t7ism traum		19a. Informant's Name/Relationship Shirley Davis /			1	_		and Number or Ru Street,				
e,	s 1 an of Heal Item 2 other		20a. Method of Disposition		20b. F	lace of Dispo cemetery, crei				Date		cation - City or To	
baitimoi	Page rent o nt: If	H	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State				ark 01/1	0/2008	Cur	nberland	, MD
	mit.	li	21. Signature of Funeral Service Lice										Home, P.A.
ñ	Deg any	h d	MILORX	addu	Uss	4	04 De	catu	ır Street	, Cumbe	rland	d, MD 2	1502
45			23a. Part1. Enter the disease, or coshock, or heart failure. List on	nplications that y one cause on	caused the deat each line.					or respiratory a	rrest,		Approximate Interval Between Onset and Death
į I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	UNG		ANIC	CE	/			>	MONTHS
	Examiner			Due to	(or as a consec	quence or):						i	
-24		ner	Sequentially list conditions, if any, leading to immediate outcor. Enter Unionying Cause (Disease or injury that initiated events	b Due to	(or as a consec	quence of):							
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
Ď,	be execian a	Ē	resulting in death, East	Due to	(or as a consec	quence or):							
04/80 04/80	physic the t	dical		d								-	
×	certifi ding se as	/Me	IF FEMALE:	23c If yes ou	utcome pf pregn	ancv						2d Data of dalis	200
gox	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live	birth 2 ☐ Feta	al death 3	⊒Ectopic pr ⊒ Other <i>(sp</i>		<i>'</i>		1	3d. Date of deliving Month	Day Year
j.	the c y the achec	hysi	9 Unknown	9□ Unkr	nown								
S,	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	inderlying c	ause giv	en in Part I.	23e. Did t			he cause of death?
ğ	equire en siç ould b	ed	LFLIAC !	D1-5 E	ASE					1 🗆	Yes 2,	Mo 3 □ Prol	ably 4 □Unknown
ecord	m (0 0)	olet								24a. Was		24b. Were auto	ppsy findings available mpletion of cause of
ř	sician: The lav certificate has irector, page 2:	Completed								perfo	rmed?	death?	2 No
Vital H	an: tiffica tor, p	BeC	25. Was case referred to medical					property.	26. Place of Dea	ath (Check only o			
	≥ .g ⊕	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient 2] ER/Outpatie	nt 3 DC	Oth	er: 4 🔯 Nursing H	lome 5 ☐ Resi	dence 6	3 □Other (Speci	fy)
o c	g Ph ter th neral	n: T	27. Manner of Death	28a. Date	e of Injury nth, Day Year)	28b. Time o	of 2	28c. Injur Wor	y at	28d. Describe	how injur	y occurred	
<u></u>	Attending Reath.	atio	1-2Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	nan, Day Toan,	,,	M		Yes 2 ☐ No				
DIVISION	or Attendater death Director:	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Plac	e of injury - At h	nome, farm, st	reet, factory	y, office		28f. Location (City or To			al Route Number,
	ital o									ļ			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		aminer: On the					me, date and place opinion, death occ				
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	4.10 110		-	290	c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)
			1 507		2/			D005	54004		Jan	nuary 7,	2008
7	5/10A		30. Name and address of person wh	o completed	ion of doath /lin	m 23a) /Tun-						7 17	
	nas		30. Name and address of person when Shiv C. Khai					High	nway, LaV	ale. MD	21	502	
	Sta	ate	31. Date filed (Month, Day, Year)	B .	Registrar's Sign			-0,	3 7 = 50	,			
	Regist		IAN 0 7 20	JA MA	141 Ja	1- 15 M	ALL.						

DHMH 17 Rev 1/2001

	0406 on Lewis D	onh			oe or Print i								egible	е.		
,			1- For State Registrar	O.	ate of Maryi		rtificate o			1110111	٠ <u> </u>		Reg. No.	20	100	3 0133
Mod	Physici ical Exami	an/	1. Decedent's	Name (First, Midd							2	Date of De Month January		Year		3. Time of Death 1415 hrs
wied سخري	icai Exami	itiei	4a. Facility Na		on Lewis			4b. City, To	wn, or L	ocation of	f Death	January		County of	Death	
*			Garrett	Co. Memorial	Hospital			Oaklar	nd					Garrett		
	Funeral Director		5. Social Secu	urity Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year Days	If Under	Min.	8. Date of t	Birth(MM/	/DD/YYYY)	Foreign	nplace (State or
	Director		218-70	0-2050	1 X M 2 F		50 Yr	s.				07/1	3/19	5.7	Cou	ntry Maryland
	any		10a. State	10b. County		10c. City	, Town or Loca	ation							П	10d. Inside City Limits
	and Show	or	MD	Gar	rett	0.	akland									1 Yes 2 No
e	Maryl r 28a-l ed at g	Director	10e. Street ar					10f. Zip (10g. Cit	izen of Wha		try?
142	ith the 23a o notifi	al Di	600 11. Marital St	Vista Sq	uare Road	#52 cedent Ever in U	18 13 W	21: as Deceden	550	anic Orig	in? (Sne	cify Yes or I	No-	USA 14. Race -		an Indian, Black,
7	leath w items	Funeral		Married 2 X				Yes, specify						White		
	after d al", or	by F	3 Widow		vorced If Yes, Give Ya	ar		Yes 2	-				,	Specify:	Whi	
	hours 'natur Exam	ted		nt's Education (Spery/Secondary (0-12)	ecify only highest gra	1-4 or 5+)	16a. Decede	ent's Usual C most of work					16b.	Kind of Bus	siness/Ir	ndustry
)36 thin 72 te. than '	Completed by	9th	y/Secondary (0-12)	College	140131)	Lab	orer					Co	onstr	ucti	on
	5-00 iled wi Hygier I other the M	ပို		Name (First, Middle	e, Last)	 			1		,	First, Middle				
	21215-0036 suld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be		s Melvin		_	19b. Maili	ng Address	(Street			e Viv			n. State.	Zip Code)
	MD 2 nd 2 shou alth and P m 27 is r aumatic	-			ham/ wife			Vista								
	re, P I and F Healt Fitem Fitem		20a. Method	of Disposition	n 3 Removal t	20b.	Place of Dispo	osition (Nam				Date	20c.	Location -	City or	Town, State
	Baltimore, permit Pages I an Department of Her Important: If ite injury or other tr		4 Donati	ion 5 Other S	Specify:		rrett	Co.Men	ı.Ga	rden	s 01/	/18/08		aklar	nd,M	aryland
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland perment of Health and Mental Hygiene. Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show: injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature	of Funeral Service	Ligensee			Name and								21550
	Physician				r complications that	caused the deat	h. Do not enter	the mode of	dying,	Secor such as ca	ardiac or	respiratory	arrest, sh	nock, or hea	art PID	21550 Approximate Interval Between Onset and
th'	/Medical			ist only one caus ause (Final diseas	D.1.	d cardion	yopathy									Death
FAL.		ľ		resulting in death)	Due to (or as	a consequence	of):									
		ner	if any, leading	list conditions, g to immediate r Underlying Cause		a consequence	of):					-				
	-	Examine	(Disease or in	njury that initiated ing in death) Last	C	a consequence	of):									
	ecuted and transit	=			d											
	ox 68760, sath certificate be exe attending physician 8 for use as the burial -	edic	X UNPE	NDED	#Z3a,Z	7.perME.g	875, 1/2	5/08 TI	1				0.	0d Data of	سمدناهاد	
	876 tificate ing phy as the	M/us	IF FEMALE: 23b. Was dec past 12 n	edent pregnant in	23c. If yes	, outcome of pre birth	gnancy	etal death	3	Ectopic	c pre gnar	псу	2	3d. Date of Month		Day Year
	Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medica		No 9 U	diameter '	gnant at time of o	death 5	Other (Spec	ify)							
	ords, P.O. Box w requires that the deatl s been signed by the att should be detached for		Part II. Other	significant cond	itions contributing		resulting in the	underlying	cause g	iven in Pa	art I.					the cause of death?
	ires that signed be det	d by			-											pably 4 V Unknown
	cords faw requi	Completed										24a. W au	topsy	l t	Vere au prior to d death?	topsy findings available completion of cause of
	Recc The lavicate ha	Som										1 🗸 Ye	erformed?		✓ Ye	es 2 No
	Vital Recysician: The his certificate director, page	Be	examiner		al Hospital:	Inpatient 2	/ ER/Outpatie	page 1700		of Death Other	-	nly one) g Home 5	Resid	dence 6	Other	··
	Division of Vital Records, P.O. rat or Attending Physician: The law requires that it is after death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated	5 T	1 ✓ Ye 27. Manner o		28a. Dat	e of Injury th, Day, Year)	28b. Time o			y at Work		28d. Descri				· - · · · · · · · · · · · · · · · · · ·
	ion tendin leath. tor: A the fur	atior	1 X Natur		nding estigation	ui, Day, 1 ear)			1 Y	es 2						
	Jivis I or At after d Direct	Certification:	3 Suici	de 6 Co	uld not be 28e. Pla	ace of Injury - At	home, farm, st	reet, factory,	office b	uilding, et	tc.		n (Street n, State)		er or Ru	ral Route Number, City
	Divis Hospital or A 24 hours after Funeral Dire	Sel	4 Hom	icide	Physician: To the be		edge, death occ	curred at the	time, da	ate and pla	ace, and	due to the c	ause(s) a	and manner	r as stat	ed.
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	(Check only one)	2 Medical Ex	aminer: On the basis	s of examination	and/or investig	gation, in my	opinion	, death oc	curred at	t the time, d	ate and p	olace, and c	lue to th	e cause(s)
	F # F 5	Ĭ	29b Signatur	re and title of certif				290		e number						nth, Day,Year)
1			0	celul	en	upo of doct ()	nm 23.0)		0.C.I	VI.□.			Ja	inuary 15	, 200	
		4			n who completed ca Assistant Medic			nn Street,	Baltin	nore, M	ID 2120	01				
		tate		(Month, PAY, Near	1 6 2008 ^{32.1}	Registrar's Signa	ature /	Sperik	-							
	Regis	strar	1		_ 0	MARCHETT CONTRACTOR	Ad A	Spirit Con								

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

							Cei	tificate (of.	Death			Reg. No.			
			1. Decedent's Nem	e (First, Middle, L	ast)							2. Dete of De Month	ath	Year	3. Time of E	Death
	Physici /Medio		JAMES	D.	DRAIN							JANUAR	Day 7 2	008	7:00	AM
>	Examin		4a. Facility Name (If not institution, g	ive street end nun	nber)			- [4b. City, To	wn, or Lo	cation of Death	4c. County	of Deeth		
			Citizer	ns Care	and Rehal	bilitat	ion Ce	nter		Fr	eder.	ick	Fr	ederi	ck	
I	Funeral Director		5. Social Security N 578-07-0		Sex, 1 M 2□ F	7. Age (In yrs. 102	last birthday) Yrs.	If Under 1 Y Months D	ear eys	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, De Aug • 1	th y, Yeer) .2 1905	Count	ace <i>(State or</i> ry) rginia	
	yland now		Usual Residence of 10a. State	f Decedent 10b. County		10c. Cit	y, Town or Lo							10	Od. Inside City	/ Limits
	Mar Field	ģ	Md.	Fred	erick		Frede	rick							1 Yes	2□No
	3e or 28	al Director	10e. Street end Nur 839 Wat	mber terford :	Orive			10f. Zip Co	de	217	02		10g. Citizen of Uni	What Count	•	
720	be filed within 72 hours after death with the Maryland tiel Hygiene. d other than "neturel", or items 23e or 28e-f show event, if a Medical Enarther must be indiffied at	by Funeral	11. Marital Status 1 ☐ Never Marr 3 🖼 Widowed	ied 2□ Married	12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	2 ⊠ No e		Wes Decedent Yes, specify	,	lispanic Ori en, Mexicar Specify:		ecity Yes or No Rican, etc.)	- 14. Rac Ble Specifi	ee - America ck, White, e		
15-0020	n 72 hou *neture edical E	Completed		15. Decedent's l	Educetion		16e. Deced	lent's Usual O kind of work d OO NOT use re	ccup one	etion during mos	t of work	ing	16b. Kind of B	usiness/Ind	ustry	-11-2
7	withi ene. than	Ĕ	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)		ruck D					Tru	cking		
7	filed Hygid ther ant, t		17. Father's Name	(First, Middle, Las			<u> </u>	LUCK D.			er's Name	e (First, Middle,	Maiden Suman			
yiand	ould be Mentel arked o	To Be	William			n					mma	Branh				
C.	S D E E	-	19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mailir	g Address (Si	treet	and Numbe	er or Rure	el Route Numb	er, City or Town,	Stete, Zip	Code)	
Ma	D E N P		Joyce I	L. Kidwe	ll / Daug	ghter	839	Water:	fo:	rd Dr.	ive,	Freder	ick, Md	. 21	702	
e C	es 1 en of Healt f Item 2 r other		20a. Method of Dis	•			lece of Dispo	sition (Neme o	of r plac	ce)	l	Dete	20c. Location -	City or To	vn, State	
more,	Pages nent of I nrt: If Ite			☐ Cremation 3 5 ☐ Other (Spec		state		n Ceme				1/14/08	Rock	ville	, Md.	
<u>=</u>	permit. Page Depertment Important: If eny Injury or once.		21. Signature of Fu	neral Service Lice	ensee		22	. Name and A	ddre	ss of Facilit	bor 1	Funeral	Homo			
מ	8 2 E 8		mu	reef of	1- Ba	when	1	P. 0.					ville,	Md. 2	0882	
	*		23a. Part1. Enter t shock, or hea	he disease, or co	mplications that ca	aused the deat									Approximate Intervel Between	(een
	Physician		SHOCK, OF Hea	irt fallufe. List offi											Onset and De	eath
	/Medical		Immediate Cause disease or condition	(Final	His	porto	ne24/0	G	10	linch	seu	la) A	Disense		1042	1
	Examiner		resulting in death)		o. 1 09	Due to (o	or as a conseq	uence of):					Disense		-	
-	D #	ine		_	. b									i		
	Bcute and -trans	Examiner	Sequentially list co	enditions,	0.	Due to (o	ras a conseq	uence of):								
3	oe ex	Ë	if eny, leeding to in cause. Enter Unde Cause (Disease or	erlying	c											
08/PU	ertificete be executed ding physician end se es the buriel-transit	edicai	that initiated events resulting in deeth)	s T	•	Due to (o	r as a conseq	uence of):								
×	a ding	₹		· ·	l d									ĺ		
0	etten for us	Physician										- 4				
j	the de	ıysi	Part II. Other signif	ficant conditions	contributing to de	ath but not res	ulting in the ur	nderlying caus	e giv	en in Part I	l .		tobacco use co			
7	that the ded by dete											1 🗆	Yes 2 No	3 ☐ Prob	abiy 4 🗆 U	Jnknown
coras,	v requires that the death c been signed by the ettenc should be deteched for us	ted by											an autopsy ormed?	ave	re eutopsy fin ilable prior to)
ပ္ထ	S E	Completed												of c	npletion of ca leath?	luse
	Page 1	ပ္ပ										10	Yes 2 No	1 🗆	Yes 2	No
VII	Physicien: The this certificete	Be	25. Was case refer examiner?	red to medical	112-1				0		of Death	n (Check only o	one)			
5		ို	1 ☐ Yes 2				ER/Outpatien		Oth	A NU			dence 6 □Oth)	
	E E E	ü	27. Manner of Deat	h 5 🗌 Pending	28a. Date o (Monti	f Injury h, <i>Dey Year)</i>	28b. Time of Injury					28d. Describe	how injury occur	red		
<u>0</u>	Attending or death. ector: After by the fune	cat	Accident 3 ☐ Suicide	investigati 6 ☐ Could not	he			М		Yes 2□					. O	
UNISION	or At	Certification:	4 ☐ Homicide	determine	286. Place	of Injury - At hog ng, etc. <i>(Specif</i>)		eet, factory, of	fice			City or To	Street and Numi vn, State)	oer or Hura	ноше мить	oer,
_	To the Hospital or Attending Phys within 24 hours efter death. To the Funerel Director: After this completely filled in by the funerel di	edical Ce	29a. Certifier (Check only		hysicien: To the laminer: On the ba											
	To the h within 2 To the F complet	Med	one)	kile certifier	and mann	er stated.		29c Li	cens	se number			29d. Date signe	d (Month I	Day Year)	
	5 <u>≥ 5</u> S	_	29b. Signature and		180	0)	> 13	_/=	20-	,		100	1	
•			10-	Jan 1	1. (1)	m			ン	-10	7/		1/1	108	i	
	Ψ			Kaufman	n, M.D.	300	W. 9t		et	, Fre	deri	ck, Md.	21701			
	Sta Registr		31. Date filed (Mon	th, Day, Year) JAN 0	9 2008 P	egistrar's Signa	ture	Sperk	,							
									-							

08-00152 **Dwight Evans**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 01335

vigit Evalis		For State	or war ylaria i		ficate of	Death			B	eg. No.	<u></u>	
Physician/		poistrar Decedent's Name (First, Middle,La	ast)						. Date of Dea Month	Day '	Year	3. Time of Death 2355 hrs
ediçal Examine	r	Dwight Evans							January 5		to of Dan	
() ()	4	a. Facility Name (if not institution, g	ive street and number)		4	b. City, Town, c		Death		Carro	nty of Dea	
		7944 Dogwood Drive				Mount Airy		0.411=0	0 Data of B	1		Birthplace (State or
Funeral	5	Social Security Number 6.	Sex 7. Ag	e (In yrs. last	birthday)	If Under 1 Ye		Min.	1		Fore	eign
Director		214-82-2276	X M 2 F	42	Yrs.				04/0	<u>9/1965</u>		MD MD
	_	sual Residence of Decedent		40 - City T	own or Location							10d. Inside City Limits
w any	1	0a. State 10b. County				JII.						1 Yes 2 X No
and sho	şL	MD Freder			<u>lerick</u>	40f Zin Codo				10g. Citizen o	f What Co	ountry?
th the Maryland th the Maryland 23a or 28a-f sho notified at once	<u> </u>	0e. Street and Number 7289	#C Coachli	ght C	t.	10f. Zip Code			1			
h the	ĪL	7289 #C Couchli			140.14/-	217 s Decedent of F		n2 / Sne	ocify Vec or N		SA Race - Am	erican Indian, Black,
r death with or items 23 must be no	1	Marital Status Married 2 Married	12. Was Decedent	Ever in U.S.	. 13. was	es, specify Cub	an, Mexican,	Puerto F	Rican, etc.)		Vhite, etc.	
or its	3		1 Yes 2	XX No		Yes 2 XX	Jo specify:			Spec	ofy: Wh	nite
ral",	3	Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:	mpleted)	16a. Deceden	t's Usual Occup	oation (Give k	and of w	ork done	16b. Kind o	of Busines	ss/Industry
"nate	3	Elementary/Secondary (0-12)	College (1-4 or		during m	ost of working li	ife. DO NOT t	use retire	ed)	1		
36 nin 72 f. f. f. f. f. f. f. f. f. f. f. f. f. f	1	7			Drywal	.1 & Cor	ncrete	Fin	isher			ction
5-0036 ed within 72 hour lygiene. other than "natu	ξþ.	17. Father's Name (First, Middle, La	ast)				18.Mother	s Name	(First, Middle	, Maiden Surn	ame)	-
21215-0036 Juld be filed within 77 Mental Hygiene. marked other than c event, the Medica		Woodland Evans,	Sr.				Oli	ive	Cather	ine Bla	<u>air</u>	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiers in the Maryland ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmite vent, the Medical Examiner must be notified at once T or D. Completed by Europeal Director		19a. Informant's Name/Relationship	(Type, Print)		1	g Address (St						
MD od 2 shoulth and m 27 is aumatin		Flora Evans/Sis	ter			#C Coad		t Ct		erick,	MD 2	21703 v or Town, State
ore, ME ss I and 2 sl of Health at If item 27 her traums	- 1	20a. Method of Disposition	2 Dameurl from S		ematory or of	sition (Name of her place)	i		Date			1
nore	- 1	1 Burial 2 Cremation 4 Donation 5 Other Spee		Sout	h Carr	coll Cre	emator	y 1/	12/200	8 Win	field	d, MD
Baltimore, permit. Pages I as Department of He Important: If ite injury or other tr		4 Donation 5 Other Special Nature of Funeral Service Li	çensee		Bu	Hamel and Add	ueéficit	uner	al Hor	ne & Cr	emat	ory, P.A.
Dep Dem	4	Francis (0	Ulle		112	12 W. O	ld Lib	erty	Rd.	Winfie	eld.	MD 21784
Physician	7	3a. Part I. Enter the disease, or co	omplications that cause	d the death.	Do not enter t	the mode of dyi	ng, such as c	ardiac o	r respiratory	arrest, shock,	or heart	Approximate Interval Between Onset and
. \- /Medical		failure. List only one cause or lor ediate Cause (Final disease	Combined	lrug int	oxicatio	on (metha	done a	1coho	ol, and	diaze am)	Death
xaminer	ſ	or condition resulting in death)	Due to (or as a cons	sequence of):							
		Sequentially list conditions,	b					_	_			
		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):							
	۱a	(Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):							
uted nd ransit			d			h # 1 07/	0/1/0	O mm				
760, icate be executed by physician and the burial - transit	Medical	X UNPENDED	X AMENDED	23a 27,2 mended	28a-f 1 tem 10e	erME,g876 per T.D	01/14/	2008	Carrol:	Co. wj	1	
60, ate be ohysici ne buri	ĕŀ	IF FEMALE:	23c. If yes, outc							23d. D	ate of del	livery Day Year
587 ortific ding p		23b. Was decedent pregnant in the past 12 months?	Due on out	at time of dea		etal death	3Ectopi	ic pregna	ancy	MC	onth	Day Teal
Box 687/ he death certifics y the attending pl	sici	1 Yes 2 No 9 Unkr	- L	at time or de	ath 5 C	other (Specify)						
y the de Ched f	Physician/	Part II. Other significant condition		ath but not re	esulting in the	underlying cau	se given in P	art I.				te to the cause of death?
that the head be detacted	출	, art iii otiid. organisesis			_				1	Yes 2 🗸 N	о 3	Probably 4 Unknown
ords, P.O. w requires that as been signed to	Completed	-			_				24a. W		24b. Wer	re autopsy findings available or to completion of cause of
cord	흺								P	utopsy erformed?	dea	th?
Rec The Is cate h	팃							(a) -		es 2 No	1 🗸	Yes 2 No
al Finn:	a l	25. Was case referred to medical examiner?	Hospital:	-			Other			Pasidona	0.6	Other: Scene
Vit hysic this o	P	1 ✓ Yes 2 No	П	itient 2	ER/Outpatier		Injury at Wor		ng Home 5	ibe how injury	لبنا	
ing P After funera	إي	27. Manner of Death 1 Natural 5 Pendi	28a. Date of i (Month, Da	njury _{ly,} Year)	ļ	1	Yes 2	unn)		,,,,,		
ion ttend Jeath. tor:	aţį	I GIIGI	tigation LFDG 1/D	/2008	Fnd 11:	чо рш			unk 28f Locati	on (Street and	Number	or Rural Route Number, City
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	Certification:	3 Suicide 6 X Could	not be		ome, tarm, str	reet, factory, off	ice building, e	BIG.	70% Joy	yn, State)	Dr Mt	. Airy, MD
D spital sours neral fillec	ĕ	4 Homicide	1	house		t till a flag						
re Hos n 24 h le Fur letely		29a. Certifier 1 Certifying Phone) 2 Medical Exam	ysician: To the best of miner:On the basis of e	f my knowled examination a	lge, death occ and/or investic	curred at the time pation, in my op	ie, date and p inion, death c	olace, an occurred	at the time,	date and place	, and due	e to the cause(s)
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transi	Medical		and manner state	ed			cense numbe					(Month, Day, Year)
	2	29b. Signature and title of certifie	1/1			i	.C.M.E.			Janua	ary 6, 2	800
WIZ		Maliporte V	ne Soull									
U		30. Name and a dress of person	who completed cause of Assistant Medic			Penn Stree	t. Baltimo	re. MD	21201)	OCME
		Margarita Korell MD.		strar's Signat							-	
Sta	ate	31. Date filed (Month, Day, Year)	2008	audi a Olyilat		rank 1						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department	artment of Health and I <i>rtificate of Death</i>		giene Reg. No 2 A A B	01336
r		Ш	Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death
	Physici /Medic		Eva	Engle	01	02 08	1425 P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	n	4c. County of Death	
			WMHS Braddock Campus 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Cumberland If Under 1 Year If Under 24 Hrs.	8. Date of Birt	Allegany	lace (State or Foreign
ь	Funeral Director		188-22-1196 1□M 2□XF 79 Yrs.	Months Days Hours Min.	7/8/19	y, Year) Coul	A (Try)
	pu ,		Usual Residence of Decedent	and in			10d. Inside City Limits
	laryla shov	'n	MD Garrett Co. Grantsvi.				1 ☐ Yes 2 ☐ No
	28a-1 notifie	rect	10e. Street and Number	10f. Zip Code		10g. Citizen of What Cou	ntry?
	h with	al Di	891 Dorsey Hotel Rd.	21536		USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. I then the marked other than "natural", or Items 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	y Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☒ No Specify:	pecify Yes or No to Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	etc.
Maryland 21215-0036	Phours atural	ed by	3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation		16b. Kind of Business/In	dustry
215	thin 72 e. an "na Medic	Be Completed	(Specify only highest grade completed) (Give life,	kind of work done during most of wo DO NOT use retired)	rking	**	
21	led wij	Con	,	emaker	(First Middle	Home Maiden Surname)	
and	d be fil ental H ed ott		17. Father's Name (<i>First, Middle, Last</i>) Harvey Hampe		e Klink	, maideri Surname)	
Ž	2 should be f and Mental I is marked ol aumatic eve	은		ng Address (Street and Number or Ri	ural Route Numb	er, City or Town, State, Zij	Code)
	1 and 2 Health a tem 27 is		Randy Engle 645	Keystone St., Mey	ersdale,	PA 15552	
altimore,	0			matory or other place)	Date	20c. Location - City or T	
Ē	t. Pages tment of l tant: If its ijury or o		4 □ Donation 5 □ Other (Specify) St. Paul			Meyersdale,	
Ba	permit. Pag Department Important: I any Injury o	n n	William K. frice	2. Name and Address of Facility P 325 Main St., Me	yersdale	e, PA 15552	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Dre to (or as a consequence of):	1 - 910	1700		1day
	Examiner		Samuellath list couldings	Heart Faile Embolism disase			1 year
	ed sit	Examiner	Gaya Disease or injury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	01:0000			2
	execut and al-trar	Exan	Cause (Disease or injury that initiated events resulting in death) Last c. Variable	Moase			Lyear
38760,	ficate be executed physician and is the burial-transit	dical	d				
89	ertifica ing ph e as th	Med	IF FEMALE:				-:-
Box	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	□Ectopic pregnancy □ Other (specify)		23d. Date of deliving Month	Day Year
о. О	hat the		9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Records,	uires t signe	d by	Alzheimer dementia		1 🗆	Yes 2 /2 No 3 □ Pro	bably 4 □Unknown
Ö	s beer s shou	Completed			24a. Was	an 24b. Were aut	opsy findings available
<u> </u>	The la	mo:			auto perfo 1 Yes	psy prior to co ormed? death? 2☑No 1☐Yes	ompletion of cause of 2.☑No
Vital	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?		ath (Check only o		
<u>_</u>	Physic this c	ပ္	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			dence 6 Other (Spec	ify)
O	ding h. After funer	tion	1	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	200. Describe	now injury occurred	
Division or	r Atten er deat rector by the	Certification:	3 Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (City or To	Street and Number or Rui wn, State)	ral Route Number,
ō	oital o urs aft eral DI			At a constant of the state of t			
	Etely fi	Medical	29a. Certifier Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Certifying Physician: To the best of my knowledge, dea and manner stated. 29a. Certifier Check only one) Certifying Physician: To the best of my knowledge, dea and manner stated.	nvestigation, in my opinion, death occ	e, and due to the urred at the time,	date and place, and due	stated. to the cause(s)
	To the within To the Somple	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	, Day, Year)
			Solsabert Namer D/	D58108	00	1/2/20	08
		И	30. Name and address of person who completed cause of death (Item 23a) (Type			1 '	631-
			31. Date filed (Month, Day, Year) 32. Pégistrar's Signature	265 Grantsvi	lle Mai	ryland 21	70 <i>0</i>
П	Sta Registi		JAN 0 4 2008	South !			

DHMH 17 Rev 1/2001

ORIGINAL

State Registrar 31. Date filed (Month, Day Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
TERRY JODRE, MD 7503 SURRATTS RUAD, CLINTON, MARYLAND 20735

	,	1 - For State Registrar	State of Maryland / D		Health and M	lental Hygi	ene ²⁰⁰⁰ g. No.	01338	
Physicia /Medic Examin	al	Decedent's Name (First, Middle, La MARIAN ADAMS 4a. Facility Name (If not institution, gi FREDERICK MEN	FEAGA		or Location of Death	2. Date of Death Month JANUARY	Day Year		
Funeral Director		Social Security Number 6.	Sex 7. Age (In yrs. last birti	hday) if Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 3,	year 9. Birt 1912 Wes	hplace (State or Foreign Untry Virginia	
s 1 and 2 should be filed within 72 hours after death with the Maryland felled and Mental Hygiene. Thealth and Mental Hygiene. The marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	rector	Maryland 10b. County Maryland Freder:	ick Frederic			10	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 No untry?	
leath with ns 23a or must be	Funeral Director	7407 Willow Ro	12 Was Decedent Ever in U.S.	21702	Hispanic Origin? (Spe	ecify Yes or No-	U.S.A.	ncan Indian,	
ours after d	by	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No			Black, Whit	e, etc. Lte	
within 72 h iene. than "natu	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed) College (1-4or 5+) 2	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Homemaker	pation during most of worki d)	ing 1	6b. Kind of Business/ Own Home	Industry	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any injury or other traumatic event, the Monee.	To Be C	17. Father's Name (First, Middle, Las Vernon S. J	Adams			Bell Dix	on		
f, Wilding 1 and 2 shu Health and em 27 is m		19a. Informant's Name/Relationship Janet B. Wallace 20a. Method of Disposition	e, niece P.0	O. Box 394,	Bendersv:	ille, PA			
it. Pages rtment of h rtant: If ite njury or of		1 ☐ Burial 2 XXX mation 3 [4 ☐ Donation 5 ☐ Other (Spec	Smith	Disposition (Name of y, crematory or other plassburg Crema	tory Jan.	16, 200	8 Smithsh		
permi Depa Impo any Ir		21. Signature of Funeral Service Lice	MO0255	106 East	nd Basfore Church St	., Frede	rick, MD 2	21701 Approximate	
Physician /Medical Examiner per parallitransit per	cal Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to Immediate cause. Enter Undertying that initiated events resulting in death) Last	a. Due to (or as a consequence of Due to (or as a consequence	Caskiolos n: n:	edar	Disers		Initierval Between Onset and Death 5 425 1 Week	
eath certifica attending ph for use as th	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 P No 9 □ Unknown	23d. Date of de Month	ivery Day Year					
w requires that the debeen signed by the should be detached	by	Part II. Other significant conditions Orabetto M	contributing to death but not resulting in	the underlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to s 2 No 3 □ P	the cause of death?	
n: The law reficate has be	Completed	Or Was and a modical				24a. Was an autopsy perform	prior to death? No 1 □ Yes	utopsy findings available completion of cause of	
hysicia this certi al directo	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) Yes 2 \(\text{No} \)		patient SUDOA		me 5 Reside	nce 6 □Other (Spe	cify)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	27. Manner of Děath 1 Natural 2 Accident Sulcide Accident Sulcide Accident Sulcide Accident Accident Sulcide Accident Sulcide Accident Accident Sulcide Accident Sulcide Accident Accident Sulcide Accident Sulcide Accident Accident Sulcide Accident								
Hospital o 4 hours aft Funeral Di tely filled in	edical Cer		hysician: To the best of my knowledge miner: On the basis of examination and			and due to the ca	use(s) and manner a		
To the within Z To the comple	Med	29b. Signature and title of pertifier	and manner stated.	29c. Licen	se number / 397 /	29	d. Date signed (Nont	h, Day, Year)	
8		30. Name and address of person who Robert L. Kau.	completed cause of death (Item 23a) (fmann, M.D., 300 W	Type, Print)		ederick,	MD 21701	,	
Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signature	goods,					

DHMH 17 Rev 1/2001

State Registrar

08-00311 Dale Fields, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 0133) ())
-----------	--	-----	-----

Concept Name (First Modes Labt) Springer Failds Sr.	e Fields, St.		For State Certificate of Death	Reg. No.
De le Piolds Sr. De le Piolds	Physicia		egistrar 2.1 Decedent's Name (First, Middle,Last)	- 1/
As 2 Early Number of Processor (As a Computer of Compu		""	D-1- Fields Cr	January 11, 2008
Special Procession	١		ta. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	
Second Second			Western Mu Health System Memorial Campus	
The property of the property o	Euperal	7	5 Social Security Number 6. Sex 7. Age (III yrs. last billiday)	Foreign Fairchan
The first files files are all the files fi		-	The latest the latest	
Truck Driver State Color County Truck Color		Ļ	183-32-7949 \(\begin{array}{c ccccccccccccccccccccccccccccccccccc	
State State	È	H	140+ City, Toyan or Location	
Specify Black Specify Black	*	- 1	Voyage	
Specify Black Specify Black	fand fand	희	111101 Ti- Codo	10g. Citizen of What Country?
Ply 10 and 10 special	Mar r 28s	ie		IISA
Ply 10 and 10 special	h the		37 Vice Decedent of Hispanic Origin? (Spec	cify Yes or No- 14. Race - American Indian, Black,
Ply 10 and 10 special	th wit	je i	11. Married Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ri	ican, etc.) White, etc.
Ply 10 and 10 special	or it	ᆵ	Yes 2 V No specify	Specify: Black
Ply 10 and 10 special	s afte		3 Wildowed 4 Divorced or Dates: 1901 03 Pecedent's Usual Occupation (Give kind of wo	
Ply 10 and 10 special	hour fratu	ted	during most of working me. Be not assure	id)
Ply 10 and 10 special	36 in 72 han	ple	Truck Driver	
Ply 10 and 10 special	with with grene her t	E O		First, Middle, Maiden Surname)
Ply 10 and 10 special	filed filed the	a)	Fyelyn	Wiltrout
Ply 10 and 10 special	112 Jd be Ments		19b. Mailing Address (Street and Number or Ru	ural Route Number, City or Town, State, Zip Code)
22. Ame and Actives of Facility Smith Funeral Home American Reviser My 26.726	Shou and h		Winian Fields / Wife 59 Orchard Street	Keyser, WV 26726
22. Ame and Actives of Facility Smith Funeral Home American Reviser My 26.726	and 2 ealth tem 2		20a Method of Disposition	
22. Ame and Actives of Facility Smith Funeral Home American Reviser My 26.726	Ore		1 X Burial 2 Cremation 3 Removal from State	
Physician acids a minor 23a Part. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardeac or respiratory arrest, shock, or heart affairre. List only one cause or condition resulting in death) 23a Enter the disease, or condition resulting in death) 23a Enter the disease, or condition resulting in death) 23a Enter the disease or injury that initiated events resulting in death) 23b Enter of linguing the death conditions 23a Enter of linguing the deat	Pag ment tant:		4 Dullation of Other Speedy	
Physician acids a minor 23a Part. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardeac or respiratory arrest, shock, or heart affairre. List only one cause or condition resulting in death) 23a Enter the disease, or condition resulting in death) 23a Enter the disease, or condition resulting in death) 23a Enter the disease or injury that initiated events resulting in death) 23b Enter of linguing the death conditions 23a Enter of linguing the deat	Salt ermit Separt mpor njury		21. Signature of Pulled College Street	Keyser, WV 26726
Tailure. List only one cause or necessary or condition resulting in death) The sequentially is stoodiffore, if any, testing to strained any property of the sequence of condition resulting in death) The sequentially is stoodiffore, if any, testing to strained any property of the sequence of condition resulting in death). Last The sequentially is stoodiffore, if any, testing to strained any property of the sequence of condition resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death). Last The sequentially is strained and included events resulting in death. Last The sequentially is strained and included events resulting in death. Last The sequentially is strained and included events resulting in death. Last The sequentially is strained and included events resulting in death. Last The sequentially is strained and included events resulting in death. Last The sequentially is strained and included events resulting in death. Last The sequentially is strained and included events resulting in death. Last The sequentially is strained and included events resulting in death. Last The sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of the sequence of th			Rock Forty the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arrest, shock, or heart Approximate Intervent
The first of the condition resulting in death) The first of the condition of conditions, if any leading to innectable to the cause of the conditions, if any leading to innectable to the cause of the conditions, if any leading to innectable to the cause of the conditions, if any leading to innectable to the cause of the conditions of			failure. List only one cause on each line.	
Sequentially list conditions, largy leading to immediate cause. Circle for lines of death of the cause of the				
The part of the pa			h	
The part of the pa		ē	if any, leading to immediate Que to (un as a consequence or):	
The part of the pa		튙	(Disease or injury that initiated	
UNPENDED UNPENDED UNPENDED	中 夏	l ×	events resulting in death). Last	
The part of the pa	xecut n and l - trau	<u>ख</u>	X AMENDED NO -075 1/21/08 TT	
Part II. Other significant conditions Part II. Other sig		5	#28f, pervit, 8873, 1/31/00 11	
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	376 ficate	1 5		ancy Month Day Year
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	c 68 certi endin use a	1.5	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	BO) dearth he att	10/2	1 Yes 2 No 9 Unknown 9 Unknown	23e Did tobacco use contribute to the cause of death?
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	or the	Ì		
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	res the	7	Hypertensive Atherosclerotic Cardiovascular Disease; Pulmonary Fibrosis	Loss Was an Loss Ware autonsy findings avail
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	ds requi	8		autopsy prior to completion of cause
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	COI law law has			
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	Re The ficate	2 2	26. Place of Death (Check	only one)
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	cian:	6	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	ing Home 5 Residence 6 Other:
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	Physical States	ਜ਼ ⊢	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	ding After	in i	(Month Day,Year) 1 Natural 5 Pending Jan 9, 2008 1700 hrs 1 Yes 2 ✓ No	
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	SiOl Ntten death ctor:	an k	28e Place of tnjury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	JVIS after after Direct	3	3 Suicide 6 Could not be determined (Specify) Single Family	or Town, State) 59 Orchard Street, Keyser, ★★₩
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	Spita bours meral		4 Homicide 29a. Certifier Coatifying Physician: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the cause(s) and manner as stated.
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	he Ho in 24 he Fu	pierei	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	Tat the time, date and place, and the
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature.	To the within	Com	and manner stated. 29c. License number	29d. Date signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day Year) 2 2008 32. Registrar's Signature:		1	1 OCME	January 12, 2008
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day Year) 3 2008 32. Registrar's Signature:			Willes	
State 31. Date filed (Month, Day, Year) 3 2008 32. Registrar's Signature:	1		1 444 Dann Street Boltimore MU 272	01
State (AXI 2 3 7111X) And AND AND AND AND AND AND AND AND AND AND	V		Alla Nasio III.	
	Pag		CAN 2 3 / HIX ASSESSMENT AS ASSESSMENT	

DC

Death

Year

29d. Date signed (Month, Day, Year)

January 12, 2008

State Registrat

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

Year,

ul

Assistant Medical Examiner

32. Registrar's Signature

Con Con 1 5 - 1

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Laron Locke MD.

31. Date filed (Month, Day

State

Registrar

31. Date filed (Month, Day, Year)

JAN 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3, 6:30 A M 2008 January Lola Mae France /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Riderwood Assisted Living Silver Spring Prince George's 8. Date of Birth (Month, Day, You Nov. 26, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 WA Social Security Number 7. Age (In vrs. last birthday **Funeral** Months 1 ☐ M 2 🖾 F 94 Yrs. 1913 536-18-2109 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ves 2 □ No Director Prince GEorge's Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3160 Gracefield Rd. 20904 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Rug Braider Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Millard May Daley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 Amherst St., Iowa City, IA 52245 Richard J. France/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ft. Lincoln Crem. 1 - 5 - 08Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln F. A. 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 5 Parkinson's Disease vears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☒ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Alzheimer's Disease 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page 2 s autopsy performed? 2 🔯 No 1□ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify Assist. Liv. 2 ER/Outpatient 3□ DOA 1 ☐ Yes 2X No မ 1 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. after death.

Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending within 24 hours afte To the Funeral Di completely filled in To the I within 2.

31. Date filed (Month, Day, Year) State JAN 0 7 2008 Registrar

29b. Signature and title



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D24093

29d. Date signed (Month, Day, Year)

January 3, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Day Month **Physician** 4, 2008 Patricia Ferreira January 2:17A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6418 Homebuilder Drive Carroll Mount Airy If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
April 22, Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 TF 70 England 1937 Director 415-68-7754 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Heath and Mertal Hygiene. The marked other than "natural", or items 23a or 28a-f show when traumaite event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Maryland Carroll Mount Airv 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6418 Homebuilder Drive 21771 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 No Yes, Give 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Therapist Mental Health item 27 is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Logan Ivy Moss Pages 1 and 2 should nent of Health and Men ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen D. Ferreira - Husband 6418 Homebuilder Drive, Mount Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Natl. Cemetery 1/28/08 Arlington, Virginia 4 Dopation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home Williams overt Damascus, Maryland 20872 26401 Ridge Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by t be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ို this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation or Attending 1. ✓Natural 2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No hours after death. Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ∠ hv .in 24 hour. .ve Funeral Dn. .v filled in bv 4 Homicide 1 Certifying Physician: T the base of examinating and a restated.
2 Medical Examiner: In the base of examinating and a restated.
2 Medical Examiner: In the base of examinating and a restated. 29a. Certifier Medical (Check only one) stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) ٥ 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed

JAN 0 8 2008

auso I death (Item 13a (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of M	arylan			t of Health		•	ienę		010	011
			1 - State Registrar			Cer	tificat	e of Deat	th		eg. Nd:	2008	Ula	344
	Physici	an	Decedent's Name (First, Middle	Last)						2. Date of Deat Month	Day		3. Time of	
	/Medic	cal	Alfreda May 4a. Facility Name (If not institution.				4h Cihi	Town, or Locatio	n of Dogth	January		, 2008 County of Death	3:15	5 p ^m
	Examin	ier	Garrett Count			spita		Oakla				Garreti		
	Funeral			6. Sex 7. Ag		last birthday)	If Under		ler 24 Hrs.	8. Date of Birth (Month, Day,			place (State o	or Foreign
	Director		219-78-9821	1□M 2 X IF	91	Yrs.	MOTOTO	Days Hours	5 14111.	July 24	1,19	916 Mai	rýlano	d
and	W. T		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	cation						10d. Inside C	City Limits
Mary	-fehi	ţo	MD Garre	. ++	Fr	iends	will	۵					1 🗆 Yes	2 X No
death with the Maryland	or 28a	Director	10e. Street and Number			Tenab	10f. Zip			1	0g. Citi	zen of What Cou	intry?	
th wit	23a c	alD	3841 Bear Cre	ek Road				2153	1			USA		
	tems lar m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	.S. 13. V	Vas Dece Yes, spe	dent of Hispanic (cify Cuban, Mexic	Origin? (Sp can, Puerto	ecify Yes or No- Rican, etc.)		 Race · Amer Black, White 		
rs aft	i, or	by F	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	ed 1 Tes 2 🕅 If Yes, Give Year or Dates:	.No	1	☐ Yes	2 X No Speci	ity:			Specify:	31	
within 72 hours after	ature cal E		15. Decedent	s Education		16a. Deced	ent's Usu	al Occupation			16b. Ki	nd of Business/li	Vhite ndustry	
thin 7	e. Mari	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or	5+)	life. D	OO NOT u	rk done during m se retired)	nost of work	ang				
1 7 Pe	ygien her th it, the		8			Homem	aker					Home		
i be fi	ntal H ed otl	Be	17. Father's Name (First, Middle, I							ne (First, Middle, I		Sumame)		
should	and Me le mark aumatic	ပ္	George Alexar 19a. Informant's Name/Relationsh			19b. Mailin	a Address			da Geor		r Town, State, Zi	D Code)	
M 25	i Health and Mental Hygiene. Item 27 ie marked other than "naturel", or items 23s or 28s-f ehow other traumatic event, the Medical Examiner must be notified at		Rita M. robir		ter		-	•		ad, Fri				2153
98 1 g	of He		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Demousl from State		Place of Dispos	sition (Nai	ther place)	I	0.0		cation - City or T	own, State	
Pages	ment tant: it		4 □ Donation 5 □ Other (Sp	ecity)		John	's (emeter	Jan. Y	11,2008	A o	ccident	, MD	
ermit.	Department of Important: if it eny injury or conce.		21. Signature of Funeral Service	icensee	1			d Address of Fac an Fun		Homes,	P	. A .		
			23a Part 1 Enter the disease or	Clum Clu	d the deat		179	Miller	_Str	eet, Gr	ant	tsville	Approximat	
DI-			23a. Part1. Enter the disease, or shock, or head ailure. List of Immediate Cause (Final	nly one cause on each li	1 /				40 00,0120	or rospitatory and	.,		Interval Bet Onset and	tween
	ysician Medical		disease or condition resulting in death)	a. Due to (or as	a conseq	eume uence of):		. /		- /			dys	
Ex	caminer		Sequentially list conditions	b	(nas	true	Hay	ut y	Tallere	_		405	
g	t is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence of):		1/+	1.	-0			- 5	
xecute	and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):	VY	ream	1)(5	use.			400	
te be e	been signed by the attending physician and should be detached for use as the burial-transit	calE		d										
	as the	_												
th cer	tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregna 2 Feta	ancy Ideath 3□	l€ctopic p	egnancy			2	23d. Date of deli-	-	Vaar
The law requires that the death certifical	the at hed fo	Physician/Med	1 ☐ Yes 2 ⊠No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of d	eath 5	Other (sp	secify)				Month	Day	Year
that th	ed by detac		Part II. Other significant condition	лs contributing to death I	out not res	ulting in the un	nderlying o	ause given in Pa	irt I.	23e. Did tot	bacco u	se contribute to	the cause of o	death?
w requires	n sign ed blu	d by	\mathcal{L}	enal T	F411	ure				1 🗆 Ye	es 2 (□No 3□Pro	bably 4	Gaknown
a v a	s bee 2 shou	Completed	·							24a. Was a		24b. Were aut	opsy findings	available
T Pe	ate ha	E O								autops perform	ned? 2 No	death?	ompletion of d 2 ☐ No	ause of
ician:	ertific ector,	Be	25. Was case referred to medical examiner?	Harrier .					ace of Dear	th (Check only on		*****		
Physic C	this or	-T	1 Yes 2 No.	Hospital: 1 Anpatio		ER/Outpatient 28b. Time of		OA Other: 4 🗆	Nursing Ho	ome 5 Reside	_		ify)	
ding C	th. : After : fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, Da	y Year)	Injury	M	Work? 1 ☐ Yes 2	□No	Zod. Describe no	zw mijur	y occurred		
or Attending	or dea octor by the	Certification:	3 Suicide 6 Could n	ot be ned 28e. Place of In- building, et			eet, factor	, office		28f. Location (St City or Town			ral Route Num	nber,
2 5	al Dir	Cert									_			
To the Hospital or Attending Physician:	within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2 completely filled.	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	Physician: To the best xaminer: On the basis of and manner st	of examina	wledge, death tion and/or inv	occurred restigation	at the time, date, in my opinion, d	and place, death occur	and due to the cared at the time, d	ause(s) ate and	and manner as place, and due	stated. to the cause(s	s)
o the	vithin i	Mec	29b. Signature and title of certifier	and marmer st			29	. License numbe	9r	2	9d. Dat	e signed (Month	, Day, Year)	
-	s = 0		1/2				r	-23979			10	8.8.		
		-	30. Name and address of person v	who completed cause of	death (Iter	n 23a) (Type, i		-23313				,		
		5	Robert A. Gor				Four	th Str	eet,	Oaklar	ıd,	MD 23	1550	
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Registr	rar s Signa		make	0						

			State of Maryland				Menta	ıl Hygiei	ne	
		·	State Registrar	Cer	tificate of L	Death	1	Reg.	No. 2008	3 01345
	Physicia	an	1. Decedent's Name (First, Middle, Last) Norman	Furn	nan		2. Dai	e of Death nth nuary	5, 2008	8:40 A M
	/Medic	al	4a. Facility Name (If not institution, give street and number)	ruin	4b. City, Town, or	Location of Death			4c. County of De	
E	Examin	er	1400 Crestridge Drive						101	
			5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	If Under 1 Year	llver Sp:	8 Dat	e of Birth	Montgo 9.B	mery irthplace (State or Foreign
	Funeral Director		579-01-6909 1XM 2 F 91	Yrs.	Months Days	Hours Min.	Ana	onth, Day, Ye	ar) (shington, DC
	40		Usual Residence of Decedent				ולאלין ו		IJIO Na	stiring con, be
	yland now at		10a. State 10b. County 10c. City, To	own or Loc	cation					10d. Inside City Limits
	a-fsl	양	Maryland Montgomery		Silver Sp	oring				1 □Yes 2 No
	or 28	Director	10e. Street and Number		10f. Zip Code			10g.	Citizen of What 0	Country?
	th wil	al	1400 Crestridge Drive		2091	LO			USA	
	ems er m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S In, Mexican, Puer	pecify Ye to Rican,	s or No- etc.)	14. Race - An Black, Wh	
õ	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1	☐ Yes 2√2 No	Specify:			Specify: Wh	ite
-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 □ Divorced Year or Dates:	Co Doord	antin Herral Occurs			406	-	
ဂ်	"nat	lete	(Specify only highest grade completed)	(Give I	ent's Usual Occupa kind of work done of OO NOT use retired	turina most of wor	rking	166	. Kind of Busines	s/industry
7	withii ene. than he M	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		iness Own	,			Restau	want
0	be filed within 72 hours after death with the Marylan ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)	_bus	THESS OWL	18. Mother's Nar	ne (First,	Middle, Maid		Lanc
and	d be ental ked c	o Be	Isaac Furman			Gertru	de So	hmidt		
₹	2 should be and Mental Is marked raumatic ev	은	19a. Informant's Name/Relationship (Type. Print)	9b. Mailin	g Address (Street a				ty or Town, State	, Zip Code)
Z Z	and 2 ;		Alan Furman/Son	111	38 Forest	Edge Di	cive,	Rest	on, VA 2	0190
ā,	工工章		Come	of Dispos	sition (Name of natory or other plac	e) 5 /0 //	Date	20c	. Location - City	or Town, State
Ē	Pages Tent of Int: If its Iry or o		1 Larburial 2 Li Cremation 3 g Hemoval from State		d Memoria	7/0/0		Fa	lls Chur	ch. VA
altimo	- 돌혈증		21. Signature of Funeral Service Licensee		Name and Addres					<u> </u>
ă	Depar Impo any Ir		Denigle C May		O Univers					, MD 20901
	1		23a. Part 1. Inter the distase, or complications that chised the death. I shock, or heart failure. List only one cause on each line.							Approximate Interval Between
	Physician	0.4	Immediate Cause (Final disease or condition a Cardiopulmon	2277	Arrost					Onset and Death
	/Medical		resulting in death) a. Calla 10 pa 1 into 1 Due to (or as a consequence							
	Examiner		Sequentially list conditions b. Aspiration F	neum	onia					
	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	ce of):						
	ecute and trans	am	that initiated events c. Colon Carcin							
Š,	be executed ician and burial-transit		resulting in death) Last Due to (or as a consequent	ce or):						
9/20	cate ohys the	dical	d							
×	death certificate e attending phys d for use as the	Me	IF FEMALE: 23c. If yes, outcome pf pregnancy	,					Ood Date of a	la liveau
ž Q	atten for u	cian	in the past 12 months?	ath 3□	Ectopic pregnancy Other (specify)				23d. Date of d Month	Day Year
j	iclan: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Cities (spearly)					
<u>.</u>	requires that the een signed by the		Part II. Other significant conditions contributing to death but not resultin	g in the un	derlying cause give	en in Part I.	23	e. Did tobac	co use contribute	to the cause of death?
Kecords	luires n sign	d by	Stroke					1 🗌 Yes	2 ▼ No 3□	Probably 4 □Unknown
ទូ	law rec as beer 2 shou	lete					24	a. Was an	24b. Were	autopsy findings available
T T	The la	Completed						autopsy performed	prior t death	o completion of cause of ?
VITAI	ificate or, pa		25. Was case referred to medical			Of Place of Day		Yes 2	No 1 LY	es 2 No
>	Physician: this certific ral director,	o Be	examiner?	Outpatient	t 3□ DOA Othe	26. Place of Dea			e 6 □Other (S)	ocity)
ō	Physer this eral dir	-	27. Manner of Death 28a. Date of Injury 28	b. Time of	28c. Injury Work	~~~~			njury occurred	<i>Эеспу)</i>
<u> </u>	Attending Physician: r death. ector: After this certific by the funeral director.	tio	1 □★Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injury		Yes 2 □ No				
DIVISION	Attendiar death.	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home building, etc. (Specify)	, farm, stre	et, factory, office			cation (Stree		Rural Route Number,
5	ppital or At burs after d leral Direc filled in by	Certification:	55mmg							
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examiner: On the basis of examination	dge, death	occurred at the tin	ne, date and place	e, and du urred at t	e to the caus	e(s) and manner	as stated. ue to the cause(s)
	To the Hos within 24 ho To the Fur completely	Medical	one) and manner stated.							
	7 with 70 Page 1	2	29b. Signature and title of certifier		29c. License 010124		7A)	29d.	Date signed (Mo	nth, Day, Year) 5, 2008
	0		" WVVVA						January	
	,		30. Name and address of person who completed cause of death (Item 23 Karim Sami Trad, MD 1800 Town C			#312 Pa	e+^~	777	0190	
	Sta	to				TOLL, RE	.acon	, VA 2	.0190	
	ાa Registr		31. Date filed (Month, Day, Year) 327 egistrar's Signature	A	30.55					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Michael FINLEY JAMES 5:17 PM 01 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SOUTHBLN LID HOSPITAZ CLINTON Prince Georges If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 08-21-1954 6. Sex 9. Birthplace (State or Foreign Funeral 10 M 2□F Months WASH, DC 579-18-5139 53 Director Usual Residence of Decedent 10a, State 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Temple Hills HD 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 lameson 2204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) PRIVATE filed withir Hygiene. Elementary/Secondary (0-12) AUTO BOOY HECHANIC PAINTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James (alvin tinley HERCEDES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any Injury or other trauonce. Sherceisha Finley DAVITHER 4014 KANSUS CLUL NW #255 WASH OF DEOIL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 □ Removal from State RIVERDALE PARK CREMANLY 4 ☐ Donation 5 ☐ Other (Specify) RIVEKOME, 40 21. Signature of Funeral Service Licenses 814 UBINCST NW WASH DC 30011 BIANCIHI 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1□ Yes 2 210 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 198 01-02-200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave SE - DC 2003 BoTello 13 SoutheRN MD 31. Date filed (Month, Day, Yea JAN 0 4 2008 32. Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

TOTAL DESIGNATION OF THE PROPERTY OF THE PROPE	The Part of the Comment of the Comme		-	For State Registrar	State of I	Maryland		artment of				giene	8	0134	+
ERNEST J. GEORGE ### Common Service and functional part server and functional ### Common Server an	ERNEST J. CEORGE J. A. 1. A. C. County Service and JANUARY 3, 2008 4.30 A. 1. SET INTO CECTL 86 LONG DRIVE 86 LONG DRIVE 87 LONG DRIVE 88 LONG DRIVE 100			1. Decedent's Name (First, Middle	, Last)								V	3. Time of De	ath
Security Name of Port Institution, give entreal and number Security Flowers (Location of Death CECK Ceck	44. Testify views of form instantion, gives served and numbers of the property			ERNEST	J.		(GEORGE						4:30 A	A
Section Sect	86 LONG DRUE BY 10 Service of the control of the c			4a. Facility Name (If not institution	, give street and numb	er)			n, or Location	of Death					
1. Special Security Numbers Displayer T. App (in print and command) Displayer New Displayer	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	LXaiiiiii	CI	86 LONG DRIVE				ELI	VTON.			CEC	ett.		
22_03_934_2 Table 20 Price of The Country 100. College 1 100. Coll	22.2—03 – 93.42 IN A CLY STORE AND STATE INC. COMPY DOES NOT CONTROL LOCATION INC. COMPY DOES NOT COMPY DOES NOT CONTROL LOCATION INC. COMPY DOES NOT CONTROL LOCATION INC. COMPY DOES NOT COMPY	Funeral				Age (In yrs. la	ast birthday)	If Under 1 Ye	ar If Under		8. Date of Birt	h	9. Birthpla	ace (State or Fo	orei
State 100 County 100 City, Town or Location 100 City, Town or Loca	Use Street on December 100 County 100	Director		222-03-9342	1 X M 2□F	90	Yrs.	Months Da	ys Hours	Min.	01/01/1	918			
DESCRIPTION OF STREET OF S	DE NEW CASTLE NEWARK 100. Store and Number 1 100. Clitton of White Country? 100. Store and Number 1 1							· · · · · · · · · · · · · · ·							
CALLDONG CAL	CALIDORO CORGI SELECTION OF Town, State 26 Code) 19. Maining Address (Streat and Automate or Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation or Through Foundation of Humil Route of Department of Humil Route of Humil Rout	Mou.		10a. State 10b. County		10c. City	, Town or Lo	cation					10		
CALLDONG CAL	CALIDORO CORGI SELECTION OF Town, State 26 Code) 19. Maining Address (Streat and Automate or Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation of Humil Route Normate or Through Foundation or Through Foundation of Humil Route of Department of Humil Route of Humil Rout	- 3	٥	DE NEV	V CASTLE			NEWA	ARK					1 ∑ Yes 2[
CALLDONG CAL	CALIDORO CIORGI SCALIDORO CIORGI 19. Malling Address (Streat and Author or Runal Return Number Corp. or Town, State, Zip Code) 19. Malling Address (Streat and Author or Runal Return Number Corp. or Town, State, Zip Code) 20. Mannor of Disposition 19. Malling Address (Streat and Author or Runal Return Number Corp. or Town, State, Zip Code) 20. Mannor of Disposition 19. Malling Address (Streat and Author) 20. Location - City or Town, State 21. Location - City or Town, State 22. Location - City or Town, State 22. Locatio	128	<u>re</u>	10e. Street and Number				10f. Zip Cod	е			10g. Citizen of W	hat Count	ry?	
CALLDONG CAL	CALIDORO CIORGI SCALIDORO CIORGI 19. Malling Address (Streat and Author or Runal Return Number Corp. or Town, State, Zip Code) 19. Malling Address (Streat and Author or Runal Return Number Corp. or Town, State, Zip Code) 20. Mannor of Disposition 19. Malling Address (Streat and Author or Runal Return Number Corp. or Town, State, Zip Code) 20. Mannor of Disposition 19. Malling Address (Streat and Author) 20. Location - City or Town, State 21. Location - City or Town, State 22. Location - City or Town, State 22. Locatio	3a o	9	16 SHE LANE				10	7711			II.S.	Δ.		
CALLDONG CAL	CALIDORO GIORDI GELSOMINA COSETTI 190. Malling Address (Stream and Amanbar or Risual Rouse Number of Copy or Town, State 2p Code) 190. Malling Address (Stream and Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse Rouse Copy or Town, State 2p Code) 190. Malling Address (Stream and Malling Amanbar or Risual Rouse R	1 2 2	Jer.		12. Was Decede	ent Ever in U.S	S. 13. ¹			rigin? (Sp	ecify Yes or No-		- America		_
CALLDORO GIORGI GELSONINA COSETTI 190. Mailing Address (Simes and Mumber or Paral Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 20a. Method of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route) 190. Paral II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of Paral Route) 20a. Date of Paral Route) 20a. Date of Paral R	CALIDORO GIORGI SCIENCE SON State	흔를	고	1 ☐ Never Married 2 🔀 Marr	ied 1 X Yes 2		İ				Hican, etc.)	Black	c, White, e	tc.	
CALLDORO GIORGI GELSONINA COSETTI 190. Mailing Address (Simes and Mumber or Paral Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 20a. Method of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Paral II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of Paral Route) 20a. Date of Paral Route) 20a. Date of Paral R	CALIDORO GIORGE COALIDORO GIORGE 190. Maling address (Stream and Number or Rival Rouse Number or Grown Flower State 2 por Town, State 2 posses of the St	2 2	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s: 1942-	1945	1∐Yes 2 X ∭	No Specify	:		Specify:	WH	ITE	
CALIDORO CINKII COLORIO CONTROL CONTR	CALIDORO GLORGI COCALIDORO GLORGI September of Fund Relationship (Type, Print) 199. Mailing Address (Streas and Munice or Relation Relun Neurolace, Oper or Town, State, 2p Code) 190. Mailing Address (Streas and Munice or Relation Relun Neurolace, Oper or Town, State, 2p Code) 190. Mailing Address (Streas and Munice or Relation Relun Neurolace, Oper or Town, State, 2p Code) 190. Mailing Address (Streas and Munice or Relation Relun Neurolace) 190. Mailing Address (Streas and Munice or Relation Relun Neurolace) 190. Mailing Address (Streas and Munice or Relation Relun Neurolace) 190. Mailing Address (Streas and Munice or Relation Relun Neurolace) 190. Mailing Address (Streas and Munice or Relation Relun Neurolace) 190. Mailing Address (Streas and Neurolace) 190. Mail	a a	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Oc	cupation			16b. Kind of Bus	siness/Ind	ustry	
CALLDORO GIORGI GELSONINA COSETTI 190. Mailing Address (Simes and Mumber or Paral Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 20a. Method of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Paral II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of Paral Route) 20a. Date of Paral Route) 20a. Date of Paral R	CALIDORO GIORGE COALIDORO GIORGE 190. Mailing Address (Streat and Muser or Risual Rouse Number of Grown States 20 Code) 190. Mailing Address (Streat and Muser or Risual Rouse Rouse Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser or Risual Rouse Rouse Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser or Risual Rouse Rouse Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser or Risual Rouse Rouse Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser or Risual Rouse Rouse Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code) 190. Mailing Address (Streat and Muser Copy or Town, State 20 Code Copy or Town, State 20 Code Code Copy or Town, State 20 Code Code Code Code Code Code Code Code	- 2	pie			0(54)	lite.	kina or work ao DO NOT use rei	ne auring mo: tired)	st of work	ing				
CALLDONG CAL	Californiants Name/Selationship (Type, Print) 199. Mailing Address (Strees and Murper or Rusual Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Printing Route Number of Route Route Number of Printing Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Number of Route Route Route Number of Route Rout	==	E	Ciententary/Secondary (0°12)			RESEAL	RCH AND	DEVELO	PMEN	T TECH.	CHEM]	CAL		
CALLDORO GIORGI GELSONINA COSETTI 190. Mailing Address (Simes and Mumber or Paral Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Mailing Address (Simes and Mumber or Route Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 20a. Method of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route Number, City or Town, State, 2p Code) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Pince of Disposation (Number of Paral Route) 190. Paral II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of death but not resulting in the underlying cause given in Part I. 20a. Date of Death (Cross or) (Paral Route) 20a. Place of Death (Cross or) (Paral Route) 20a. Date of Paral Route) 20a. Date of Paral Route) 20a. Date of Paral R	CALIDORO GIORGE COALIDORO GIORGE 199. Maling Address (Streak and Author or Fixual Pixual Neuroless Cay or Town, State, Zip Code) 190. Maling Address (Streak and Author or Fixual Pixual Neuroless Cay or Town, State, Zip Code) 20a. Method of Disposition 10 Date of Disposition (Theorem State) 20b. Place of Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State) 20b. Disposition (Theorem State)	a th	a)	17. Father's Name (First, Middle,	Last)										
198. Information Name Name Resistance 199. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	198. Informants Name/Relationship (Type, Print) 198. Malling Address (Street and Number or Rival Rouse Number, Cliptor Town, State 2 Doctor Town, State 2	0 P 0	00	CALIDORO GI	FORGT				CFI	OMTN	rΔ CO	CETT			
ERNEST C. GEORGE SON 20a. Method of Disposition 20b. Place of Disposition	ENNEST C. GEORGE SON 20a. Méthod of Disposition 20b. Please of Deposition (Name of D	mari	۴				19h Mailir	na Address /Str				4.00	State Zin	Code)	
23a. Set 1. Effer the Jesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac corespiratory arrest. Immediate Cause (final death) Immediate Cause (final death) Due to (or as a consequence of): Due to	23. Set 1. Enter the Blassas or complications that caused the death. Do not enter the mode of dying, such as cardiac or exeptratory arrest. Immediate Cause (Phal classes or complications that caused the death.) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury the cultury or death) Last Due to (or as a consequence of): Due to (or a	7 ls trau			7.9								J. G. C. J.	0010)	
23. Set it the the bases, or complications that caused the death. Do not enter the mode of dying, such as cardiac correspiratory arrest. Immediate Cause (Phal death of the subtring in death) Due to (or as a consequence of): Due to (or as a c	23a. Bart 1. Differ the jleases or complications that caused the leasth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Phal disease or conflicing in death) Due to (or as a consequence of): Sequentially its conditions, and continue that it is a consequence of): Due to (or as a consequence of): Due t	ther			E / SON	20b. Pl							City or Toy	vn State	_
23a Soff Life the Jassas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or expiratory arrest. Immediate Cause (Phal classes or condition resulting in death) Due to (or as a consequence of): Due to (o	23. Birt I for the jease or complications that caused the eath. Do not enter the mode of dying, such as cardiac corespiratory arrest. Interval Between Chistory and Cause (Phal disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequenc	F 0			3 Removal from Sta							EOO. COORGOT	ony or 10.	in, olato	
23. Set in the the Jasses, or complications that caused the death. Do not enter the mode of dying, such as cardiac our espiratory arrest. Immodate Cause (Phal disease or conflictions and Death of Due to (or as a consequence of): Due to (or as	23a Bart I. Defer the Blasses or complications that caused the leasth. Do not enter the mode of dying, such as cardiac occrespiratory arrest. Immediate Cause (Phal disease or confolions) a Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or injury the post of pregnancy or injury the post of pregnancy or injury	ury ury		4 ☐ Donation 5 ☐ Other (S	pecify)	MEM	ORIAL	CEMETE	RY	01/0	8/2008	BEAR,	DE		
23. Set it the the bases, or complications that caused the death. Do not enter the mode of dying, such as cardiac correspiratory arrest. Immediate Cause (Phal death of the subtring in death) Due to (or as a consequence of): Due to (or as a c	23a. Bart 1. Differ the jleases or complications that caused the leasth. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Phal disease or conflicing in death) Due to (or as a consequence of): Sequentially its conditions, and continue that it is a consequence of): Due to (or as a consequence of): Due t	D A D		21. Signature of Funeral Service	Licensee		S1	2. Name and Ad	dress of Facil	ity J FIIN	ERAL HO	MES INC	,		
23a. Suff. I. Enter the Jassas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or crespiratory arrest; immediate Cause (Final disease or comflicing in death) Due to (or as a consequence of):	23a Bert II. Effect the Jissaea or complications that caused the death. Do not enter the mode of dying, such as cardiac or designatory areast, inches or download in the cause of conditions and beath of conditions. Sequentially its conditions. S	E = 9	ļ	* XIny CS	МО	0840	10	000 N. I	DUPONT	PKWY	. NEW	CASTLE,	DE I	9720	
FFEMALE: 23b. Was docodent pregnant in the past 12 months? 1	FFEMALE 236. Was deceeded pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Perspanal at time of death 5 Other (specify) Month Day Year 4 Month Day Year Month Day Day Day Day Day Day Day Day Day Day Da	ď.		cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or										
1 Yes 2 Mo 3 Probably 4 Unking a available of completion of cause death? 1 Yes 2 Mo	1 Yes 2 Mo 3 Probably 4 Unknown 24a. Was an autopsy performed 25. Was case referred to medical examiner 1 Yes 2 Mo 1	by the attending pached for use as	hysician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birtl 4 ☐ Pregnan	h 2 ∐ Fetal ntattime of de	death 3							•	ar
Second S	The part of the pa	be o	þ	Part II. Other significant condition	ons contributing to deal	th but not resu	ilting in the u	nderlying cause	given in Part	l.			_		
27. Manner or Death 1	29a. Certifier Concert only 29a. Certifier Concert only 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 29a. State 31. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Date filled (Month, Day, Year) 36. Date filled (Month, Day, Year) 36. Describe now injury occurred in the filled of Could not be lower? 1	cete has bee	Complet								autop perfo	rmed? p	rior to con leath?	roletion of caus	aila se
27. Manner or Death 1	27. Manner or Death 1	ector	00	25. Was case referred to medical examiner?						e of Deat	h (Check only o			Step	_
27. Manner or Death 1	29a. Certifier (check only 2) Medican examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print) 21. Manner 7 Death 1 Matural 5 Pending investigation 28a. Date of Injury 28b. Dime of Injury 28b. Describe now injury occurred Home 28b. Describe now injury 2bb. Describe now injury occurred Home 28b. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury 2bb. Describe now injury	this c			1 🗆 1np			IL SLI DOA	4 🗆 🗅 🗅	lursing Ho		6 ∰Othe	er (Specify	Daugh	t
29a. Certifier (Unex only one) 29b. Signature and title of certifier 29b. Signature and due to the cause(s) and manner as stated. 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30c Nume and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number	29a. Certifier (Check only 2) Medical Examinat: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier (Signature) and difference one) 29c. License number (Month, Day, Year) 30c. Nime and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number (Month, Day, Year) 30c. Nime and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature			1 Natural 5 ☐ Pendin	9	Day Year)					28d. Describe I	now injury occurre	ed		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and due to the cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed	29a. Certifier (Check only 2 I Medical Examinat: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38 Name and address of person who completed cause of death (Item 23a) (Type, Print) 38 Name and address of person who completed cause of death (Item 23a) (Type, Print) 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	the fi	cati	2 ☐ Accident investi	gation not be					JNo					
29a. Certifier (Linex only one) 29b. Signature and difference and due to the cause(s) and manner as stated. 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 36 Nime and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year)	29a. Certifier (Chack only 21) Medical Examinat: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38 N Ime and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 38 N Ime and address of person who completed cause of death (Item 23a) (Type, Print) 38 N Ime and address of person who completed cause of death (Item 23a) (Type, Print) 39 N Ime and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32 N Ime and address of person who completed cause of death (Item 23a) (Type, Print)	rect by	ŧ.	dotom	ined 28e. Place of	f Injury - At hor , etc. <i>(Specify</i>)	me, farm, st	reet, factory, off	сө				er or Rural	Route Number	r,
30-Nime and address of person who completed cause of death (Item 23a) (Type, Print) Claria Simonson MDIII West High St. Suite 302 Elkion N	36 Nime and address of person who completed cause of death (Item 23a) (Type, Print) Claria Simonson MD III West High St. Suite 302 El King M State 31. Date filed (Month, Day, Year) = 200 32. Registrar's Signature	e 6	Ce		•										
30-Nime and address of person who completed cause of death (Item 23a) (Type, Print) Claria Simonson MDIII West High St. Suite 302 Elkion N	36-Nime and address of person who completed cause of death (Item 23a) (Type, Print) Claria Simonson MD III West High St. Suite 302 El Kt., M State 31. Date filed (Month, Day, Year) = 200 32. Registrar's Signature	F E	a	29a. Certifier 1 Artifyir	g Physician: To the b	est of my know	wiedge, deat	h occurred at th	e time, date a	nd place,	and due to the	cause(s) and ma	nner as st	ated.	
30-Nime and address of person who completed cause of death (Item 23a) (Type, Print) Claria Simonson MDIII West High St. Suite 302 Elkion N	36 Name and address of person who completed cause of death (Item 23a) (Type, Print) Claria Simonson MD III West High St. Suite 302 El Ktan M State 31. Date filed (Month, Day, Year) = 200 32. Registrar's Signature	Jetel	edic	one) Z Medical	and manne	r stated.	ion and/or in	vestigation, in n	iy opinion, de	atn occur	ied at the time,	oate and place, a	ina que to	ine cause(s)	
30-Nime and address of person who completed cause of death (Item 23a) (Type, Print) Cloria Simonson MD III West High St. Suite 302 Elkion N	30° Nime and address of person who completed cause of death (Item 23a) (Type, Print) Claria Simonson MD III West High St. Suite 302 El Kten M State 31. Date filed (Month, Day, Year) = 200 32. Resistrar's Signature	S T T	Ă	29b. Signature and title of certifie				29c. Lic	ense number			29d. Date signed	(Month, L	Day, Year)	
6 Glaria Simonson MD III West High St. Suite 302 Elkton N	State 31. Date filed (Month, Day, Year) = 200 32. Registrar's Signature			N OV	∂ .		1	MD 1	100	56	1119	1/4	10	\supset	
6 Glaria Simonson MD III West High St. Suite 302 Elkton N	State 31. Date filed (Month, Day, Year) = 200 32. Registrar's Signature	ĺ	1	30 Nime and address of passes	who completed cause	of death (Item	23a) /Tuno	Print			771	1/1	, –	6, , 2	214
31 Data filed (Month Day Year) 32 Pathtrate Cincature			1.0	in ine and address of person	mile completed cause	A C 1	I I I	1	HI	5	10	to 21	77 1	FIKL	1
		0		31 Date filed (Month Day Vard	20 20 L	trar's Sinn		251	11196	^ 0	1.04	1100	امر د	11/194	14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear -30 pm **Physician** Denise Marie Gubisch TAN. -08 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth Month, Day, Year) Sept. 2, 1961 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 TVF 213-88-1628 Marviland 46 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at Maryland Carroll 1 ☐ Yes 2 XNo Director New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3638 Franklinville Road 21776 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hyglene.
Instit if team 27 is marked other than "natural", or tlems 23.
Iny or other traumatic event, the Medical Ex minter must ury or other traumatic event, the Medical Ex minter must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ۾ Specify: 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Health Aide Government Guild 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rufus Pultz Beverly Louise Shifflett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
724 Cloverfields Drive Stevensville, Maryland 21666 19a. Informant's Name/Relationship (Type. Print) Hollie M. Gubisch -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; if Ite
any Injury or ot 14 Burial 2 □ Cremation 3 □ Removal from State Rock Creek Cemetery 1/8/2008 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK **Physician** SEPTIC disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ROHN'S DISEASE Sequentially list conditions, if any leading 15 in models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed and Due to (or as a consequence of) attending physician at for use as the burial-Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1∐ Yes or Attending Physiclan; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records, P.O. Box 68760 To the Hospita. Within 24 hours after death.

To the Funeral Director: After a contact of the Funeral Director of the funeral of the further and the further a

29b. Signature and title of certifier

29c. License number 30263 29d. Date signed (Month, Day, Year)

3-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS KHCD MD 200 MEMORIAL

AVE, WESTMINSTER, MD

State Registrar

31. Date filed (Month, Day, Year)

JAN 0.7 2008

FRANCIS KHOO, MD



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nó.) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 6:00 AM Levolia Haizlip Goolsby Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Silver Spring Fox Chase Rehab & Nursing Cen. Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days Months Hours Min. 1 □ M 2 🗙 F Director 579-26-5871 93 12/22/1914North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1X Yes 2 No Directo Washington DC N/A 10g. Citizen of What Country? 10e. Street and Number 20011 4017 Illinois Ave., N.W. U.S. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: Black þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Licensed Practical Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Isaac William Haizlip Laura Starbuck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20012 Great Cheryl J. Sanders /Niece Morningside Dr., N.W. Washington, D.C. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lincoln Mem. Cem. 1/9/2008 Suitland, MD 21. Signature of Funeral Service License 22. Name and Address of Facility McGuire Funeral Service, Inc DC200 7400 Georgia Ave., N.W. Washington, 23a. Part1. Enter the disease, or complications they caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ai or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burlar-transit of the state of the second of the state of the second of the Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛛 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 X No 2 No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 Pending 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Division or Vital Records, P.O. Box 68760 within 24 hours a

To the Funeral C

completely filled

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Ravi Passi, M.D. 31. Date filed (Month, Day, Year) JAN 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

8609 Second Ave., #404B Silver Spring, MD 20910 egistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D28656

29c. License number

29d. Date signed (Month. Dav. Year)

January 3, 2008

			For State Registrar			rtificate of	Death	Re	g. No. 🤈 🗎 🗎	3.01350
н	Physici	an	1. Decedent's Name (First, Middle, I	·				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Helen Estelle Gra			T #: 611 T		anuary	4c. County of Dea)]] . /
	Examin	er	4a. Facility Name (If not institution, g		2		or Location of Death		Char	
	.		5. Social Security Number 6.		s. last birthday,	LAPI If Under 1 Year	If Under 24 Hrs 9	B. Date of Birth	O. Pi	rthplace (State or Foreign
	Funeral Director		214-42-6992 Usual Residence of Decedent	1□M 2ÅF 63	Yrs.	Months Days	Hours Min.	(Month, Day, 1-14-19	44 Mar	yland
	rland ow		10a. State 10b. County	10c. (City, Town or L	ocation				10d. Inside City Limits
	Mary Ff sh fied	tor	Maryland Charle	25	Waldo	rf				1)XXYes 2 □ No
	h the or 28g	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	th wil	Funeral Director	2614 B Ferguson (Court		2060			USA	
	r dea tems er mi	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I	Hispanic Origin? (Spec oan, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Am Black, Wh	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐧 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	hite
5-0	72 h 'natu dical	Completed	15. Decedent's (Specify only highest g	Education grade completed)	16a. Dece	edent's Usual Occu kind of work done	pation during most of working ed)	7	6b. Kind of Business	s/Industry
121	vithin	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)			nd)		MaDanald	
7	iled v Hygie ther 1 nt, th	ပ္ပ	9th. 17. Father's Name (<i>First, Middle, La</i>	st)	<u></u>	<u>ashier</u>	18. Mother's Name	First. Middle. M	McDonald	5
ano	d be i	Be							,	ican
<u> </u>	2 should be filed with and Mental Hygiene, is marked other that aumatic event, the M	우	James Atchison 19a. Informant's Name/Relationship	(Type. Print)	19b. Mail	ing Address (Street	t and Number or Rural		King Atch City or Town, State,	
	nd 2 salth an 27 is		Robin Graham/ Hu	ishand	2416	R Fernusa	on Ct Wald	orf Ma	ryland 2	0603
re,	es 1 and of Health fitem 27 rother tr		20a. Method of Disposition	206	. Place of Disp	osition (Name of ematory or other pla	n Ct. Wald	te 2	Oc. Location - City o	r Town, State
Baltimore,	Page nent c nt: If		1X Burial 2 □Cremation 3 4 □ Donation 5 □ Other (Spe	Hemoval from State		Cemetery	1	-2008 W	aldorf, M	arvland
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lic	20000	2	22. Name and Addre	ess of Facility Hun	tt Fune	ral Home	
. 6	8 3 5 6 8	1.)	1 KM	mol.			lashington			20601
п			23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the de ily one cause on each line.	eath. Do not en	iter the mode of dy	ing, such as cardiac or	respiratory arre	st,	Approximate Interval Between
M	Physician	p 4	Immediate Cause (Final disease or condition	CRIPTOGE	NEC(I	DIOPATI	DEC) CI	enlas	, ZZ	Onset and Death
	/Medical Examiner		resulting in death)	Bue to (or as a cons			100 100			1
R.	Examine	L	Sequentially list conditions,	D		UN-1-15	rower			* W ec/43;
	D #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	equence on:)			
	xecut and Il-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
68760,	be e sician buria									
687	rificate be executed ng physician and as the burial-transit	edic	223	d						
Box	eath cert attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre		□ □			23d. Date of de	elivery
	The law requires that the death ceitte has been signed by the attendir hage 2 should be detached for use	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time o		□Ectopic pregnanc □ Other (specify) _			Month	Day Year
P.0	at the by th tache	hys	9 ☐ Unknown	9□ Unknown						
	uires tha signed d be dei	by F	Part II. Other significant conditions	s contributing to death but not r	esulting in the I	underlying cause gi	ven in Part I.		. /	to the cause of death?
ord	w requir been si should	ted						1 □ Ye	s 2/25 No 3 □ F	Probably 4 Unknown
Vital Records,	law I	Completed						24a. Was an	24b. Were a	autopsy findings available completion of cause of
=		Con						perform 1 Yes 2	ned? death?	s 2□No
Vita	sician: The law certificate has be irector, page 2 s	Be	25. Was case referred to medical examiner?	Hasnital:		104	26. Place of Death	(Check only one	2)	
or	this b	P	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 28a. Date of Injury	ER/Outpatie	nt 3 DUA			nce 6 □Other (Sp	ecify)
Division or	ding P. After 1 funera	Certification:	1 Natural 5 ☐ Pending	(Month, Day Year) Injury	Wo	iryat ork?]Yes 2 □No	od. Describe no	w injury occurred	
Sign	death ctor: / the	icat	3 Suicide 6 Could not	be See Blood of injury As	home, farm, st			St. Location (Str	reet and Number or I	Rural Route Number,
O	after Dire	ertif	4 ☐ Homicide determine	building, etc. (Spe	ecify)			Cify or Town	, State)	, , , , , , , , , , , , , , , , , , , ,
_	Hospital or Attence 24 hours after death Funeral Director: etely filled in by the 1		29a. Certifier Certifying	Physician: To the best of my I	knowledge, dea	th occurred at the t	ime, date and place, a	nd due to the ca	use(s) and manner	as stated.
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Ex	caminer: On the basis of exam and manner stated.	ination and/or i	nvestigation, in my	opinion, death occurre	d at the time, da	ate and place, and d	ue to the cause(s)
_	To the within 7 To the comple	Ň	29b. Signature and title of certifier	1	$\overline{}$	29c. Licen	se number	29	d. Date signed Moi	nth, Day, Year)
			Jun (Inal m	m	1 107	0624		11410	7
(30/ Ime and address pason wh	o completed cause of death (I	tem 28a) 1	Print)	~ ~ ~		0 - 10	107
	DB 10	1	CITEURESE	1 MATION	~ ~	M, M	まこって	in M	X 20	602
	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Registrar's Sig		parke				
	riogion			7,000	1	por l				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1			1 - State Registrar	State of Maryland / I			nt of Ho te of D		l Me	ntal Hy	giene Reg. No.	/ 111	8	01351
É	Dhuaisi		Decedent's Name (First, Middle, Last,						2.	Date of De	eath			3. Time of Death
4.5	Physici /Medio		Handy Gloster						J	anuar	y 4,	2008	ear	4:50 p M
	Examin	er	4a. Facility Name (If not institution, give			4b. Cit		Location of De			4c.	County of		
	Funeval		Washington Advent 5. Social Security Number 6. Security Number		rthday)	If Und	Takor er 1 Year	na Park If Under 24 H		Date of Bi	rth		tgom	ery ace (State or Foreign
	Funeral Director			XM 2□F 73	Yrs.	Months		Hours Mi	n.	(Month, D	ay, Year)		Countr	Carolina
	pu ,		Usual Residence of Decedent	1.0 0. 7										
	show	2	10a. State 10b. County	10c. City, Tow	n or Loca	ation							10	d. Inside City Limits 1 ☐ Yes 2 X No
	the N 28a-f notifie	Director	Maryland Princ 10e. Street and Number	e George's	-	1	wie ip Code			Т	10a Citi	izen of Wha		
	3a or	٥	3108 Apple Green	I.ane		1	20716					USA	ii Counti	у:
	death	Funeral	11. Mantal Status	12. Was Decedent Ever in U.S. Armed Forces?	13. W			spanic Origin? n, Mexican, Pu	(Specif	y Yes or No		14. Race -		
336	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Affiled Forces: 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			ecity Cubar 2☐★No	Specify:	епо ніс	an, etc.)		Specify:	White, et Bla	_
5-0036	72 hor	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a	. Decede	ent's Us	ual Occupa	tion	en alein a		16b. Ki	ind of Busin	ess/Indu	ıstry
21	within iene. than "I	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. Do	O NOT	use retired)	uring most of w	rorking					
121	Hygiel Hygiel Her ti		12 17. Father's Name (First, Middle, Last)		As	ses		10. Mathada N	/5	Took Afficially	_		Gove	rnment
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, the Mec	Be	John Gloster					18. Mother's N Ochama	,		, Maiden	Surname)		
ary	shoul nd Me mark	ပ	19a. Informant's Name/Relationship (Ty	pe. Print) 19b	. Mailing	Addres	ss (Street a	nd Number or			per, City o	or Town, Sta	ate. Zip (Code)
	1 and 2 Health a em 27 is		Handy Eugene Glo					Green						
altimore,	Pages 1 annount of He		20a. Method of Disposition ★□ Bunal 2 □ Cremation 3 □ F	removal from State	ry, crema	atory or	other place	· Ja	Date n.	11,	20c. Lo	ocation - Cit	y or Tow	n, State
alti-	# P # = 1		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		_			ery: &&#Yin</td><td>200</td><td></td><td>1 110</td><td></td><td></td><td>d, Marylan</td></tr><tr><th>m</th><th>Departi Departi Importany Ir</th><th></th><th>1 (molen) S</th><th>Cole</th><th>1</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>, MD 20901</th></tr><tr><th>п</th><th></th><th></th><th>23a. Part1. Enter the disease, or compleshock, or heart failure. List only or</th><th>idations that caused the death. Do no cause on each line.</th><th>not enter</th><th>r the mo</th><th>de of dying</th><th>, such as card</th><th>iac or re</th><th>espiratory a</th><th>arrest,</th><th></th><th> 1</th><th>Approximate Interval Between</th></tr><tr><th></th><th>Physician /Medical</th><th></th><th>Immediate Cause (Final disease or condition resulting in death)</th><th>Sepsis</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>Onset and Death</th></tr><tr><th>1</th><th>Examiner</th><td></td><td></td><td>Due to (or as a consequence</td><td>of):</td><td>1.</td><td>1.</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><th>></th><th>All de</th><td>Jer</td><td>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury</td><td>Due to (or as a consequence</td><td>0):</td><td>100</td><td>we</td><td></td><td></td><td>-</td><td>6</td><td></td><td>-</td><td></td></tr><tr><th></th><th>ocuted nd transii</th><td>Examin</td><td>Cause (Disease or injury that initiated events resulting in death) Last</td><td>Must</td><td>ma</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><th>68760,</th><th>ficate be executed physician and is the burial-transit</th><td></td><td>resulting in death) cast</td><td>Due to (or as a consequence</td><td>of):</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><th>687</th><th>ficate physi s the l</th><td>edical</td><td></td><td>d</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></tr><tr><th>Box</th><th></th><td></td><td>IF FEMALE: 23b. Was decedent pregnant</td><td>3c. If yes, outcome pf pregnancy</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>23d. Date o</td><td>f deliver</td><td>v</td></tr><tr><th></th><th>death</th><td>Physician/M</td><td>in the past 12 months? 1 ☐ Yes 2 ☐ No</td><td>1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown</td><td></td><td></td><td>oregnancy specify)</td><td></td><td></td><td></td><td></td><td>Month</td><td></td><td>Day Year</td></tr><tr><th>P.0</th><th>at the d</th><td>Phys</td><td>9 Unknown</td><td>- 11-</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><th>Vital Records,</th><th>law requires that the death cert as been signed by the attending 2 should be detached for use a</th><td>þ</td><td>Part II. Other significant conditions con</td><td>ntributing to death but not resulting in</td><td>n the und</td><td>derlying</td><td>cause give</td><td>n in Part I.</td><td></td><td></td><td>tobacco u Yes 2</td><td></td><td></td><td>cause of death?</td></tr><tr><th>S</th><th>w require</th><td>lete</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>24a. Was</td><td></td><td></td><td></td><td>sy findings available</td></tr><tr><th>Re</th><th>e L e</th><td>Completed</td><td></td><td></td><td></td><td></td><td>-</td><td></td><td>-</td><td>auto perf</td><td>psy ormed?</td><td>prio dea</td><td>r to com</td><td>pletion of cause of</td></tr><tr><th>ita</th><th></th><td>Be C</td><td>25. Was case referred to medical</td><td></td><td></td><td></td><td></td><td>26. Place of D</td><td>eath (C</td><td>1∐ Yes theck only</td><td>one)</td><td>1 1 _</td><td>Yes 2</td><td>2 ∐ No</td></tr><tr><th>or V</th><th>ils din</th><td>2</td><td>examiner? 1 Yes 2 No</td><td>lospital: Impatient 2 ER/Ou</td><td>utpatient</td><td>3 □ □</td><td>OA Other</td><td>r: 4 ☐ Nursing</td><td>Home</td><td>5 🗆 Res</td><td>idence</td><td>6 □Other</td><td>(Specify)</td><td></td></tr><tr><th></th><th>ine ine</th><td></td><td>27. Manner of Death 1 ■ Natural 5 ■ Pending</td><td></td><td>Time of Injury</td><td></td><td>28c. Injury Work</td><td></td><td>280</td><td>l. Describe</td><td>how injur</td><td>ry occurred</td><td></td><td></td></tr><tr><th>Division</th><th>or Attending ifter death. Director: After in by the funer</th><td>icati</td><td>2 Accident investigation 3 Suicide 6 Could not be</td><td>28e. Place of injury - At home, fa</td><td>rm stree</td><td>M et facto</td><td></td><td>es 2, No</td><td>206</td><td>Location</td><td>(Carrona a a -</td><td>al Alcondon</td><td> O1</td><td>Da de Marcha</td></tr><tr><th>Diγ</th><th>al or A after i Direc d in b)</th><td>Certification</td><td>4 ☐ Homicide determined</td><td>building, etc. (Specify)</td><td>irii, stree</td><td>ei, iacio</td><td>ry, onice</td><td></td><td>281</td><td>City or To</td><td>wn, State</td><td>e)</td><td>or Hurai</td><td>Route Number,</td></tr><tr><th></th><th>To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu</th><td>Medical C</td><td>29a. Certifier (Check only one) Certifying Physical Exami</td><td>siclan: To the best of my knowledge ner: On the basis of examination an and manner stated.</td><td>e, death o</td><td>occurre estigatio</td><td>d at the time n, in my op</td><td>e, date and pla inion, death o</td><td>ce, and</td><td>due to the</td><td>cause(s)</td><td>) and mann d place, and</td><td>er as sta d due to</td><td>ited. the cause(s)</td></tr><tr><th></th><th>To the within 2 To the complet</th><td>Me</td><td>29b. Signature and title of certifier</td><td></td><td></td><td>25</td><td>c. License</td><td>number</td><td></td><td></td><td>29d. Dại</td><td>te signed (f</td><td>Month, D</td><td>lay, Year)</td></tr><tr><th></th><th>10</th><td></td><td>1</td><td></td><td></td><td>0</td><td>0000</td><td>49X</td><td>3</td><td></td><td>1/</td><td>y/m</td><td>۶</td><td></td></tr><tr><th></th><th></th><td></td><td>30. Name and address of person who co</td><td>- 43 -</td><td>(Type, Pi</td><td>rint)</td><td>1</td><td></td><td>71.1-</td><td></td><td>0.</td><td>1 (</td><td>2 17</td><td>g₁₀</td></tr><tr><th></th><th>-04</th><td></td><td></td><td>2021 7600 CAT</td><td>P.C.</td><td>u</td><td>TUEN</td><td>ME, 1</td><td>MIL</td><td>mp</td><td>MAR</td><td>-1c, 114</td><td>) H</td><td>1112</td></tr><tr><th></th><th>Sta Registr</th><th></th><th>31. Date filed (Month, Day, Year) JAN 0 8 200</th><th>32 Segistrar's Signature</th><th>Son</th><th>A.</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></tr></tbody></table>						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** MARILYN 2008 GILLMAN JANUARY 6, 7:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CASEY HOUSE MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2√2 F Yrs. Director 098-24-3892 78 MAY 18, 1929 BROOKLYN, NY Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It was a 12 is marked other than "natural", or items 23a or 28a-f show a 72 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD MONTGOMERY BETHESDA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9516 BECK COURT 20817 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: WHITE ð 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUYER RETAIL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JACK NAGEL ANN LEVY 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSS GILLMAN/SON 114 E 84th STREET, NEW YORK, NEW YORK 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any Injury or oth 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State KNOLLWOOD CEMETERY 01/07/2008 4 ☐ Donation 5 ☐ Other (Specify) QUEENS, NEW YORK 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the dis shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician a OVARIAN CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clisease or injury that initiated events Due to (or as a consequence of) Examiner the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2⊠No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) \square HOSPICE 1 ☐ Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred i or Attending F after death. 1X Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident Director 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral C 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Checi and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa D0064615 JANUARY 6, 2008 ne and address of person who completed cause of death (Item 23a) (Type, Print) DR. GENEVIEVE ANNE WROBLEWSKI, 1355 PICCARD DRIVE, ROCKVILLE, MARYLAND

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

JAN 0 7 2008

legistrar's Signature

Physician Division or Vital Records, P.O. Box 68760

/Medical Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran After thi within 24 hours after death

To the Funeral Director:
completely filled in by the the Hospital

Funeral

Director

28a-f show a or 28a-f sh

"natural", or Items 23a

r than "

if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M

permit. Pages 1 Department of H Important: If Ite any Injury or ot once.

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

Certification: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Sterner M. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D., 19 Che 19 Chesapeake Beach Rd. Fast, Owings, MD 20736 Gerald P. Sterner

D 12245

11, 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician FRANCIS JAN. 2008 /Medical EDWARD HERBERT 4:204b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **X**XM 2 □ F 578-28-8500 81 SEP.30,1926 WASHINGTON, DO Usual Residence of Decedent 10a. State 10c. City, Town or Locetion 10d, Inside City Limits 10b. County 1 ☐ Yes 2 No Directo PRINCE GEORGE's FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1702 LEE ROAD 20744 S. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No à 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PUMP OPERATOR D.C. GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WILLIAM DOUGLAS HERBERT MABEL ELIZABETH PRATHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE HERBERT / WIFE 1702 LEE ROAD FT. WASHINGTON, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JANUÄRY Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) NAT. CEMETERY 19,2008 | SUITLAND, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. Jat ory 5635 WASHINGTON AVE. LA PLATA, 20646 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death CARDIOMYOPATHY Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2**5** No 3 DOA 1 M Inpatient 2 ☐ ER/Outpatient

physician and the burial-transit Box 68760, as nse (P.0. the þ Records, has page certificate Division or Vital

Funeral

Director

ns 23a or 28a-f shov must be notified at

ural", or Items 2 I Examiner mus

7 is marked other than "natural", traumatic event, the Medical Exa

s 1 and 2 should be fil if Health and Mental H item 27 is marked ott

permit. Pages 1 ar Department of Hea Important: If item; any Injury or other

Physician /Medical

Examiner

within 72 hours after

Maryland 21215-0036

altimore,

Examiner Physician/Medical þ Completed Be After this 2 Certification: To the Hosping... ... within 24 hours after death.

To the Funeral Director: Af

Medical Registrar

Hospital or Attending

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ux Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

WD 0048153

ERIC ANTWI - DONKOR

CLINTON

29d. Date signed (Month, Day, Year)

20735

mb

01-15-2008

PISCATAWAY SUITE ROAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature IAN 23 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

750

WI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:30 PM 1/14/2008 Marv E. Heffner /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Glade Valley Nursing Rehab. Frederick Frederick 8. Date of Birth (Month, Day, Year) 9 / 2 7 / 1 9 0 7 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Director 217-10-9677 100 MD Usual Residence of Decedent a or 28a-f show t be notified at 10a State 10b. County 10c City Town or Location 10d. Inside City Limits 1 KTYes 2 □ No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with "natural", or Items 23a 114 East 7th Street 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ģ 3 Nidowed 4 Divorced White Completed the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than any Injury or other traumation. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William C. Geesey Maime Bowers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Heffner Son Wood Court Thurmont MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 1/19/2008 Frederick, MD Mount Olivet Cem 21. Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford P.A. Man M01176 106 East Church St. Frederick, MD 21701 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke 1 Day disease or condition resulting in death) /Médical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Light that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-tran Due to (or as a consequence of) physician Physician/Medical the attending properties of the second IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 Tes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 2 X No 1∐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760, Division or Vital Records,

Hospital or Attending within 24 hours after ueau...

To the Funeral Director: After the funeral by the the

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certified

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

801 Toll House Ave #E-1 Frederick, Saeed Α.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 43091

29d. Date signed (Month, Day, Year)

1/15/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day Year **Physician** BERT WHITTINGTON HENRY 3:22 P M 2008 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ₹M 2 □ F Months Days Hours Min. 238-40-0577 Director 78 SEP 22, 1929 NORTH CAROLINA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 TyYes 2 □ No Director HAVRE DE GRACE MARYLAND HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 119 GEORGE COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Nes 2 No If Yes, Give Year or Dates: 1948–60 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK Itimofe, Maryland 21215-003 2 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COLLEGE 12 CUSTODIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f EDDIE F. HENRY MINNIE A. CHADWICK and 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Health ar Important: If Item 27 is any Injury 611 N. ADAMS STREET, HAVRE DE GRACE, MARYLAND 21078 TERESA MARTIN / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. FERRIS & CO., INC 01/07/08 WEST CHESTER, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A - Coleman 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a con equence of) Examiner CHI Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): cal Physician/Medi IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CAD, CHF, Chronic Renal Disease 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 Yes 2 No 3 Probably has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1□ Yes 25. Was case referred to medical examiner?

1 ★Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title 29c. License number Dertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Schneider m.D. 520 Upper Chesapeake Dr. Suite 306 Bel 417, MD 21014

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year January 2, 2008 N. Hordes 10:30 A Juliet /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1801 East Jefferson Street #601 Rockville Montgomery 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 12, 1909 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 TF Months 98 New York Director 101-32-5865 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show "natural", or items 23a or 28a-f shovidical Examiner must be notified at 1∏Yes 2□No Director Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 1801 E. Jefferson Street, # 601 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 2 3 X Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Teacher Public Schools traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Katie (Unknown) Samuel Kronovet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau
once. Jess N. Hordes - Son 9507 Midwood Road, Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Old Montefiore 1/3/2008 St. Albans, New York 21. Signature of Funeral Service License 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc. Donald 20852 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused a death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastric Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Anemia, Coronary Artery Disease, 1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Unstable, Angina, Hypertension 24a. Was an cate has page 2 s autopsy performed? 2/2 No al or Attending Physician: T s after death. Il Director: After this certificat 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D002 J884 Dilino 2/208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Damien J. Doyle, MD 1801 East Jefferson Street Rockville, MD 20852 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 07 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 6 2008 15:35 Physician January **JEROME** HOLTZ RALPH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 01 ne v 4005 Queen Mary Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Hours Months 1 X M 2 | F 73 Pennsylvania April 3 1934 190-26-0130 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ırı is marked other than "natural", or items 23a or 28a-f show 'traumatic event, <u>the Medical Examiner must be notified at</u> 1 Yes 2 No Director Olney Md. Montgomery the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with United States 20832 4005 Queen Mary Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify. ð 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Flementary/Secondary (0-12) filed within Hygiene. Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be and Mental Luther Helen Α. Holtz Edwin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2::
Department of Health ar Important: If item 27 is any injury or other trau 4005 Queen Mary Drive, Olney, Md. Patricia A. Holtz / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Md. 4□Donation 5▼Other (Specify)entombment Gate of Heaven Cem. 1/11/08 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licenses muri 20882 Box 5038, Laytonsville, P. O. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final breest netastat **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown signed by t I be detach 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate has performed. 1☐ Yes 2 No Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 □ No hours after death.

uneral Director: A
ely filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OX D 5342 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

31. Date filed (Month, Day, Year)

Edward P. Taubman, M.D. 32. Registrar's Signature

2008

Registrar

18109 Prince Philip Dr., #275, Olney, Md.

20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar		aryland / Dep			d Mental Hy	Reg. No.	01359
Physic /Medi		Decedent's Name (First, Middle, Las Dibeh	Hajjar		_			1, 2008 Yeer	3. Time of Death 8:35 A
Examir		4a. Facility Name (If not institution, give		a (la ven la at histhola v	Gaithe	n, or Location of C ersburg par If Under 24		4c. County of Dear	у
Funeral Director		5. Social Security Number 594-70-2660 6. Security Number 1994-70-2660	ox 7. Ag □M 2∏ F	e (In yrs. last birthday) 86 Yrs.	Months Da		Hrs. 8. Date of Bir (Month, Da Dec. 2		hplace (State or Foreig buntry) banon
Maryland a-f show	ctor	10a. State 10b. County Maryland Montgome	ery	10c. City, Town or L					10d. Inside City Limits ↑ Yes 2 No
th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 16 Supreme Court			10f. Zip Cod 20878			10g. Citizen of What Co Lebanon	
If E. E. E. C. C. C. C. C. C. C. C. C. C. C. C. C.	Þ	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent If Yes, specify 0 1 ☐ Yes 2		? (Specify Yes or No Puerto Rican, etc.)	2 5 10	
within 72 ho ane. then "natur a Medical I	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)		(Give life.	DO NOT use re	ne during most of	f working	16b. Kind of Business Own HOme	Industry
e ta b	To Be Co	17. Father's Name (First, Middle, Last) Rizk Touma			emaker	18. Mother's	Name (First, Middle,		
is 1 and 2 should by Health and Men item 27 is marke other traumatic.		19a. Informant's Name/Relationship (7						er, City or Town, State, 208 20c. Location - City or	
Pages ment of ant: If it		20a. Method of Disposition 1 🗵 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify 21. Sportule of Funeral Service Licen)	National	Memori	piace)		Falls Chur	
permit. Departing Imports any injuice.		23a. Part 1. Enter the disease, or compshock, or heart failure. List only	Seth Min	so M	oney &	King Fun	eral Home	Inc. Vien	na, Va. Approxim 180 Interval Between
ate be executed Amedical Examiner and Invision and Invisional transit Invisional	lical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of the United States) that initiated events resulting in death) Last	b. Due to (or as	er's Disea: a consequence of): a consequence of): a consequence of):	se				
The law requires that the death certificat the has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₾ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregna ⊒ Other <i>(specify</i>			23d. Date of de Month	ivery Day Year
w requires that been signed b	ρ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	inderlying cause	given in Part I.		obacco use contribute to Yes 2¶ No 3 ☐ Pi	the cause of death?
stcien: The law requires to certificate has been signe rector, page 2 should be	Completed						24a. Was autop perio 1 □ Yes		utopsy findings available completion of cause of 2 No
lcien: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	L. La a side for		- 27		Death (Check only of	one)	
Phy this rat di	tion; To	1 ☐ Yes 2 🕸 No 27. Manner of Death 1 🗗 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	ent 2 ER/Outpatie ry 28b. Time o y Year) Injury	f 28c. [Other: 4 □ Nursii njury at Work? 1 □ Yes 2 □ No	28d. Describe I	dence 6 Other (Spe how injury occurred	cify)
tal or Attending 's after death. el Director: After ed in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inbuilding, et	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, off	28f. Location (S City or Tox	Street and Number or Ri wn, State)	ural Route Number,	
To the Hospital or Attr within 24 hours after de To the Funerel Direct completely filled in by the	edicai	(Check only 2 Medical Examone)		f examination and/or in	vestigation, in n	ny opinion, death o		cause(s) and manner as date and place, and due	to the cause(s)
T S S S S S S S S S S S S S S S S S S S	Σ	29b. Signature and title of certifier	rive U	Iro Gleu		ense number		Jan. 2, 20	•
-[30. Name and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of person who define the same and address of the same address of the same address		eath (Item 23a) (Type,			card Drive e, Md. 210	,Suite 100 042	
Sta Registi		31. Date filed (Month, Day, Year) JAN 0 8 20	20 minte	ar's Signature	carles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland		artment of H rtificate of L		Mental Hyg	giene Leg. No.	08	01360
			Decedent's Name (First, Middle, La	st)					2. Date of Dea		Vaar	3. Time of Death
н	Physici		Susan Patricia H	ehron					January	6, 200	Year 08	10:34 a ^M
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City, Town, or	Location of Dea			ty of Death	·
4	Examili	iei	9715 Winery Cour				Gaither	shure		Mont	gomery	7
	-		5. Social Security Number 6. S		e (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Birth	3	9. Birtho	lace (State or Foreign
	Funeral Director			□M 2 X)F	47	Yrs.	Months Days	Hours Mir	APR 19	1960	Penns	sylvania
	_		Usual Residence of Decedent									
	land		10a. State 10b. County		10c. City	, Town or Lo	ocation				1	0d. Inside City Limits
	Many Hear	Į.	Maryland Montgom	erv	Gait	thersb	urg					1 ☐ Yes 2 ☐ No
	28e	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	with ya	Ō	0715 Winamy Cour	+			20879)		United	Stat	es
	eath	era	9715 Winery Cour	12. Was Decedent	Ever in U.	S. 13.			(Specify Yes or No-		ace - Americ	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28e-1 show other treumatic event, the Medical Examinet must be rightlind at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Provinced	Armed Forces? 1 ☐ Yes 2 📆 If Yes, Give Year or Dates:			If Yes, specify Cuba 1 ☐ Yes 2 💢 No	n, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	Spec	ack, White, ify: Whi	
ð	2 hou	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	ation	and in a	16b. Kind of	Business/Inc	dustry
15	n "n	piet	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5	5.1	(Give life.	kind of work done of DO NOT use retired	furing most of w)	rorking			
212	lene.	E	Elementary/Secondary (0-12)	2	o+)	Cont	ract Mana	ger		MAMSI	Insur	ance
	filled Hygie other ent, I	e C	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden Suma	ame)	
a	Mental Merked o	To B	James Frederick	Aebi				Joan		McMul1	.en	
Maryland	should nd Men marke umatic	F	19a, Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a	and Number or I	Rural Route Numbe	r, City or Tow	n, State, Zip	Code)
Ma	d 2 street		Jowan Quintana /	Daughter		8803	Crosswick	ks Ct.,	Montgome	rv Vil	lage,	MD 20886
Ġ,	1 ar Heal tem 2	1.3	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	1	Date	20c. Location		
٥	nt of		1 ☐ Burial 2 X Cremation 3 ☐		Riv	enetery, crei erdale	natory or other place Park	(a) O 1 / (2000	Ddanoad	-1. N	Januar Land
Ħ	t. Pi		 4 □ Donation 5 □ Other (Special States of Special Sp			Cremat	Ory 2. Name and Addres		08/2008	Riverda	are, r	Maryland
Baltimore	permit. Pages 1 and 2 shoul Department of Health and Mi Important: If Item 27 Is mark any njury or other treumati 2005.		+ for / Mile	MOO	0956	I G	hibadeau 33 Gist <i>I</i>	Mortuai Avenue,	ry Servic LL, Silv	er Spr	ing, M	
			23a. P. 1. Enter the disease, or con- shock, or heart failure. List only	plications that caused one cause on each li	d the death	n. Do not ent	ter the mode of dyin	g, such as cardi	ac or respiratory ar	rest,	10	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Custo		L.J.	V ho.	hc	110 (hon	tooven	a bel	Onset and Death
	/Medical		resulting in death)	a Oue to (or as	a consequ		new rice	7 1311 130	To Con	I o Cl V ZI	1	Um-
	Examiner		tero-construction accomplished	. Cara	bro	Vasc	ular a	cr id	250			1)(
		ē	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injuried quarts	Due to (or as			0,1		<u> </u>			
	uted d ansit	盲	Cause (Disease or injury that initiated events									
	al-tra	xa	resulting in death) Last	Due to (or as	a consequ	uence of):						
8760,	icate be executed physicien and s the burial-transit	dicai Examiner		d								
387	phy:	gio		_ 0.								
×	death certifi e attending od for use as	N/M	IF FEMALE:	23c. If yes, outcome	of pregna	ıncy				23d. D	Date of delive	erv
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Fetal	Ideath 3	Ectopic pregnancy Other (specify)				Month	Day Year
O.	the de	ysic	1 ☐ Yes 2 💢 No 9 ☐ Unknown	9□ Unknown	t time of di	out.						
0.	hat thid by detac	by Physician/M	Part II. Other significant conditions	contributing to death b	out not resi	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	obacco use co	intribute to t	he cause of death?
Records,	wrequires that the death been signed by the atte should be detached for		, 						101	∕es 2□No	3 🗆 Prot	bably 4 Nnknown
Ö	v req beer shou	Completed							24a. Was	an 24t	. Were auto	opsy findings available
3e	e la has	d H							_ autop		prior to co	impletion of cause of
-	: The cate had	S							1 ☐ Yes	2A No	1 Yes	2 🕅 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Magaital			Oth		eath (Check only o	ne)		
of	S 5	2	1 Ves 2 □ No	Hospital:		ER/Outpatie		4 LJ Nursing	Home 5X Resid			fy)
n	fter	- Lo	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time of Injury	Wor		28d. Describe h	now injury occ	urrea	
Sio	Attending r death. ector: After by the fune	ati	2 Accident investigation					Yes 2 □ No				
Division	r Att ter de Irect	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of In building, et	iury - At ho ic. (Specif	ome, farm, st y)	reet, factory, office		28f. Location (S City or Tox		nber or Run	al Route Number,
Q	Ital of Ital of Ital of Ital	Cel		1					l.			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	Check only 2 Medicel Exa	hysician: To the best miner: On the basis o and manner st	of examina	tion and/or in	vestigation, in my o	pinion, death oc	courred at the time,	date and place	e, and due t	o the cause(s)
	roth Within Foth	Me	29b. Signature and title of centifier				29c. Licens	e number		29d. Date sigi	ned (Month,	Day, Year)
	-75°		1 July 1	lok in	700	った	100	00428	5	Jan	フ	2008
•	>		30 Name and address of parson who	completed cause of	death (Item	n 23a) (Type	Print) > 1 ~ 1	most	Cal Pi	M/K L	V	
			LRA N BRE	SHAR IM	0001	n E	5,1,0	SOVI	m m	0 2	090	2
	C+	ate	31. Date filed (Month, Day, Year)	32 egisti	rar's Signa	ature	2,1061	Pol	1			
	Regist		30. Name and address of person who IRA PRESIDENT STATES AND A STATES A	008	e d	K A	Selection of the select	,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:09 PM William Otis Harrison 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Regional Wicomics eninsula 8. Date of Birth (Month, Day, Year) Jan. 6, 1943 Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1 X M 2 □ F Maryland 65 Director 213-42-2481 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10a. State Cambridge 1 ☐ Yes 2 No Dorchester Director 28a-f Pages 1 and 2 should be filed within 72 hours after death with the I nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-ury or other traumatic event, the Medical Examiner must be notif 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21613 5305 Spring Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) plant worker concrete 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Estelle Lednum Charles Otis Harrison ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5305 Spring Drive, Cambridge, MD 21613 Bonnie Hastings daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/9/08 Salisbury, MD Salisbury Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ASCVD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): Examiner law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown organ fail 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Morbid obesit has perform 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient ိုင 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred i or Attending Pafter death. Medical Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

JAN 0 9 2008

Felder



s of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St.

William Harrison

140064534

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Mae Hubbard 5 2008 anuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Memorial Hospita 10160t 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 29, 1912 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 XF 95 Director 401-30-0098 Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1ÆYes 2□No Director Maryland Caroline Denton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 713 Market Street 21629 United States of America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Caucasian 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Health and Mental William Jay Hammons Mills Anne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) lean Hurst Denton,
Date Manyland 21629 20c. Location - City or Town, State Daughter 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Capitol Crematory 1/7/2008 4 ☐ Donation 5 ☐ Other (Specify) Dover, Delaware 21. Signature of Funeral Service License 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, aulopul love denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Infection Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Division or Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2**X** No 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√2 No ို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hyme 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAZ HOSI 31. Date filed (Month, Day, 32 Registrar's Signature State 2008 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

RA 9+1

State Registrar

DHMH 17 Rev 1/2001

Carroll St., Salisbury, MD 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

100 E.

JAN 0 9 2008

Chris Snyder

31. Date filed (Month, Day, Year)

1/6/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 364 Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Joseph Alfred Holland 5:00 A M lanuary 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Caroline Home</u> Lor Hospice Denton Caroline 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 1 № M 2 🗆 F Months Days Hours Min. 83 218-16-6576 July 9, 1924 Kansas Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1√2 Yes 2 No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 Market Street 21629 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 No Specify: Specify:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ns 23a or 28a-f show must be notified at Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or items
any injury or other traumatic event, the Medical Examiner mu
once. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Director

Funeral

10a. State

Funeral

Director

Physician /Medical Examiner

burial-transit been signed by the attending physician should be detached for use as the buria

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funeral

품	C Tridowed 4 Divorced	real of Dates.				Cai	icasian				
letec	15. Decedent's Ed (Specify only highest gra	lucation ade completed)	16a. Decedent's Us (Give kind of v	vork done during most of w	orking 16b	. Kind of Business	s/Industry				
Be Completed b	Elementary/Secondary (0-12)	College (1-4or 5+)	Maintenan	use retired) ace Forman		Poultry	Plant				
Se C	17. Father's Name (First, Middle, Last,				ıme (First, Middle, Maid		reare				
P	Clifton Ez	ra Holland									
	19a. Informant's Name/Relationship (Type. Print)	Zip Code)								
	Sylvia K. Holland	Wife	Telegrana Live								
	20a. Method of Disposition 1.☑ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)	Removal from State	Place of Disposition (N. cemetery, crematory of rton Cemete	ame of rother place)	Date 20c	. Location - City or enton, Mc	r Town, State				
	21. Signature of Funeral Service Licer		22. Name a	and Address of Facility Funeral Home ath Second St	1000						
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	th. Do not enter the mo	ode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	juence of):	End St	age		Officer and Death				
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injlury that initiated events resulting in death) Last	с	Due to (or as a consequence of): Due to (or as a consequence of):								
ıysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 ⊟Ectopic			23d. Date of de Month	livery Day Year				
ted by Ph	Part II. Other significant conditions of	thre hear	t tail	Ure	23e. Did tobacc		o the cause of death? robably 4 □Unknown				
Comple		onary h	a perte	hslon	24a. Was an autopsy performed′ 1□ Yes 2	? death?	utopsy findings available completion of cause of				
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
9	1 Yes 2 Ne	1 Inpatient 2 2	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (8								
ation	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred					
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	ome, farm, street, facto	ry, office	28f. Location (Street City or Town, Sta	and Number or Rate)	ural Route Number,				
cal	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of my kno	wledge, death occurre	d at the time, date and place	e, and due to the cause	(s) and manner a	s stated.				

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

Karen Moffett 31. Date filed (Month, Day, Year,

JAN

30. Name and address of person who completed cause of death (

D.O.

7 2008

n 23a) (Type, Print)

29c. License number

Maryland

29d. Date signed (Month, Day, Year)

and manner stated

609 32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Delath ROSE MARY HOWARD Jamuary 2008 7:35 $P \, \mathsf{M}$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Citizens Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 31, 1935 West Virginia Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 236-50-4264 1□M 2√2F 72 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland | Frederick 1 ☐ Yes 2 XNo New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10658 Emmaline Drive 21774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Management Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Price Tda Bostic nd

permit. Pages 1 and 2 should be filled wi Department of Health and Mental Hygien Important: If item 27 is marked other tht any Injury or other traumatic event, the once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f show

er than "nature , the Medical E

Director

Funeral

ģ

Completed

Be

the Maryland

within 72 hours after death with

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

as use atten for u ed by the a been signe should be page (R within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

			raa bo	0010		
19a. Informant's Name/Relationship Leonard N. Howar		19b. Mailing Address 4244 Heady	(Street and Number or vaters Lane	Rural Route Number, Ci , Olney, Ma	ty or Town, State,	Zip Code) 0832
20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	□Removal from State	Place of Disposition (Nancemetery, crematory or other of Heaver	ther place)		Location - City o	r Town, State
21. Signalure of Funeral Gervico Lice	Palley	RÖBERT 1201 NO	dAddress of Facility E. DATLEY ORTH MARKET	& SON FUNER ST., FREDE	AL HOMES	, P.A.
23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nelications that caused the deat			iac or respiratory arrest,	itz ort j	Approximate
Immediate Cause (Final disease or condition resulting in death)	1. 1. 1. h	uneme)	Drin			Interval Between Onset and Death
resulting at death)	Due to (or as a conseq	uence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter unuenying Cause (Disease or injury	b. Due to (or as a conseq	uence of):				
that initiated events resulting in death) Last	c Due to (or as a conseq	uence of):				
	▲ d	<u> </u>				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Vo	23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ll death 3 □Ectopic pr			23d. Date of de Month	elivery Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying ca	ause given in Part I.	23e. Did tobaco	o use contribute t	to the cause of death?
				1 ☐ Yes	2 No 3□P	Probably 4 🗀 Unknow
				24a. Was an autopsy performed	prior to	
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
1 ☐ Yes 2 No		ER/Outpatient 3 DO	A Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Spe	ecify)
27. Manner of Death 1 Natural 5 Pending Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of 28b. Time of Injury M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ome, farm, street, factory	office	28f. Location (Street City or Town, St	and Number or R ate)	lural Route Number,
29a. Certifier (Check only one)	hysician: To the best of my kno mlner: On the basis of examina and manner stated.	wledge, death occurred attion and/or investigation,	at the time, date and pla in my opinion, death oc	ce, and due to the cause curred at the time, date	(s) and manner a and place, and du	is stated. le to the cause(s)
29b. Signature and title of certifier	Pafun	1 -	License number		Date signed (Mon.	th, Day, Year)
30. Name and address of person who		23a) (Type, Print)		4		-
Robert L. Kaufmar	, MD 300 West	9th Street,	Frederick,	Maryland 2	21701	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 9 2008

Sperke

32. Registrar's Signature

			1 _ State	State of Maryla		artment of F		d Mental Hy		08	01366
		40	Registrar 1. Decedent's Name (First, Middle, Last)			inicate or	Dealli	2. Date of De	Reg. No.		3. Time of Death
13.	Physici /Medi		BARBARA K	HIGGI	115			Month	Day	Year	0142 AM
	Examir		4a. Facility Name (If not institution, give str			4b. City, Town, o	r Location of De		4c. County		57 12 71
		5	Anne Arundel	Yedical Ce	nter	Anna	polis,	MD	Ann	e Aru	indel C.
	Funeral		5. Social Security Number 6. Sex	4 2 VIE	s. last birthday)	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, Da	th ıy, Year)	9. Birthplac	e (State or Foreign
	Director		Usual Residence of Decedent	74	Yrs.			4/8/	1933	Virgi	lnia
	land ow at		10a. State 10b. County	10c. (City, Town or Lo	cation				10d.	Inside City Limits
	Mary Frsh fied	ţō	Maryland Anne Arund	le1	Edge	water					1 ☐ Yes 2 No
	h the r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	?
	th wil		3819 Outrigger Driv	re		2103	7			USA	
	be filed within 72 hours after death with the Maryland that Hyglene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12	. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	ispanic Origin?	(Specify Yes or No erto Rican, etc.)	14. Rac	ce - American ck, White, etc.	
36	s afte ; or it amin	by Fi	1 Never Married 2 Married	1 ☐ Yes 2 🐧 No If Yes, Give		1□Yes 2X No		5115 1 115411, 5151)	Specif		
215-0036	hours tural' al Ex	d b	3 X Widowed 4 □ Divorced	Year or Dates:	16- D					MITT	
င်	in 72 "na" r ledic	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of v d)	vorking	16b. Kind of B	usiness/Indust	try
7	with jiene. r thar the N	mo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	1	memaker	,		Но	me	
פַ	e filed Il Hygi other /ent, tl	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle			
land	ould be Mental arked o	ToB	Earl Kuper				Sus	ie Billin	gsley		
Mary	shol	٦,	19a. Informant's Name/Relationship (Type	. Print)	19b. Mailin	g Address (Street	and Number or	Rural Route Numb	er, City or Town,	State, Zip Co	ode)
	and 2 ealth n 27 l		Kim D. Fantozzi/ Da		123	Cross Pos	int Driv	ve, Owing	s, MD 20	0736	
9	jes 1 of H	П	20a. Method of Disposition 1	20b.	Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Date	20c. Location -		, State
altimore,	permit, Pages 1 and 2 should b Department of Health and Menti Important: If item 27 is marked any injury or other traumatic e once.		4 □ Donation 5 □ Other (Specify)		kemont	Cemetery	1/5	5/08	Davidso	onville	e, MD
200	permit Depart Import any in		21. Signature of Fuheral Service icensee					George P.			
	00 2 8 0		14 auc					land Rd.		er, MD	21037
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the de- cause on each line.	ath. Do not ente	er the mode of dyin	g, such as card	iac or respiratory a	rrest,	Int	oproximate terval Between nset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Corebrou	ascula	n ac	uden	t		0	lays
	Examiner			Due to (or as a conse	equence of):						U
	<u>t. – 58 </u>	er	Sequentially list conditions, it says a sequentially list conditions, it says a sequentially cause. Enter Underlying Cause (Disease or injury that initiated events could be in indicated events.	Due to (or se a nonee	quaring off):					, ,	jear,
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	atrial "	Fibril	lation				1	Lears
ر ک	exec an an rial-tr		resulting in death) Last	Due to (or as a conse	quence of):					_ -	<i>[</i>
0/00,	cate be executed physician and the burial-transit	dical	d								
	ng ph	Med	IF FEMALE:								
6	Attending Physician: The law requires that the death certific affects and early rector. After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome pf preg 1□Live birth 2□Fe		Ectopic pregnancy				te of delivery	
	the a	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown		Other (specify)			Mo	nth Day	y Year
	hat the detacl		Part II. Other significant conditions contri	buting to death but not re	culting in the un	darking ogues give	n in Dort I	22a Did t		-16A- A- Ab	
Ď,	ires t signe	by	are in other significant conditions contin	butting to death but not re	suring in the un	denying cause give	ти Рапт.	23e. Dig t	obacco use cont ∕es 2□ No		
2	/ requ	etec				· · ·			ES 2 140	3 ☐ Probably	/ 4 CONKNOWN
ב	has l	Completed						24a. Was	sy	prior to comple	findings available etion of cause of
5	n: Th ficate r, pa(05.00					1□ Yes		death? I∐Yes 2.≝	No
-	sicia certi irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hos	pital:	7500	2 DOA Othe	· · ·	eath (Check only o			
5	y Phy er this eral d	\vdash	The state of the s	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA]	4 LI Nursing	Home 5 ☐ Resid	ience 6 Oth		
5	nding Ith. 7: Afte e fun	ţi	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 □ \	:? ∕es 2 □ No		ion injury occur.		
2	Atte	IĘ CŚ	a Classic GC Could not be	28e. Place of injury - At t building, etc. (Spec	nome, farm, stre	et, factory, office		28f. Location (S	Street and Numb	er or Rural Ro	oute Number,
5	s afte	Certification:	4 I Tomicide	building, etc. (Spec	ny)			City or Tov	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death, and the Tothe Funeral Director. After this certificate has been signed by the attending a completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Lertifying Physici	an: To the best of my kn	owledge, death	occurred at the tim	ne, date and pla	ce, and due to the	cause(s) and ma	inner as stated	d.
	the H the F the F nplete	Medical		and manner stated.	ation and/or inv			curred at the time,	date and place,	and due to the	cause(s)
	vitl To		29b. Signature and title of certifier	1.67		29c. License	number		29d. Date signed	Month, Day,	, Year)
	120	M	Muy Johan	1 MD		PS	2111		() ()	18	
	MA	1	/ -	leted cause of death (Ite				100	1 '		
	Stat	0	Hung T. Davis, M.D 31. Date filed (Month, Day, Year)	32. Projetrar's Sign		kwy., Ann	apolis,	MD 2140			
	Registra		JAN 0 3 200		B A	rack .					

08-00037 Liben Hailu Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Post Control	en Hailu	J		State of Maryland / Department of 1- For State Certificate of Registrar	
4.5 Failly Named or American Control Control Find Director The Control Control Control Find Director The Control Control The Control Control Find Director The Control Control The			an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year January 2 2008 1410 hrs
Soots South Plane S. See S		٠,		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
Director of the property of the control of the cont					
The state of the					Months Days Hours Min. Oct 13 1962 Ethiopia
Maryland Montgomery Gaithersburg Second S		ny			tion 10d. Inside City Limits
The record tearing The rec	p	show a	_		
The record tearing The rec	Maryla	r 28a-f	irecto		
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	with the	ns 23a o e notifi		11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	as Decedent of Hispanic Drigin? (Specify Yes or No-
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	er death	, or iten r must b	Fune	1 Yes 2 X No	
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	ours afte	atural" camine	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Deceder	nt's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	36 in 72 ho	han "na Jical Ex	plete	Elementary/Secondary (0-12) College (1-4 or 5+)	Firm
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	5-00;	other the Me	Com		
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	121 d be fill	arked	Be	Hailu W. Semaiat	
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	AD 2 2 shoul	27 is m matic	۲	1 1 1 1	
22. Signature of Sprent Service Liverson (1) Part I. O E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (1) Fune al. Home, 20 E. Deer Park Drive, Gaithersburg, MD 20877 Physician (2) Fune al. Control of the course of the cours	re, h	f item		20a. Method of Disposition 20b. Place of Disposition	sition (Name of cemetery, Date 20c. Location - City or Town, State
Physician (Medical Examiner) 22a Fat I Feliat the religions to the country of th	timo Page	rtant:		4 Donation 5 Other Specify:	s cemetery 2008 Maryland
The state of the	Bal	Injury Por Injury			
The part of the pa				23a, Part En ler the is ase, or complications that caused the anti- Do not enter to failure. List only one cause on each line.	Between Onset and
The contribution of the co					Dedui
Operation Company Co			ē	if any, leading to immediate Due to (or as a consequence of):	
Operation Company Co			amin	(Disease or injury that initiated C.	
28. Was decedent pregnant in the past 12 months? 1	recuted	and - transit	ial E)	d	
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	60, ite be e	hysiciar e burial			23d. Date of delivery
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	687 certifica	nding p	ian/l	23b. Was decedent pregnant in the past 12 months?	State Goalin - Land Francisco
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	Box e death	the atte ed for u	hysic	1 Yes 2 No 9 Unknown g Unknown	
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	P.O.	gned by e detach	þ	Part II. Other significant conditions contributing to death but not resulting in the	
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	rds,	been si should b	leted		
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	Reco The law	cate has	dmo:		performed? death?
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	tal Fician:	certifi rector.	a)	evaminer?	TOwns .
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	of Vi	fter this neral di	-	1 Yes 2 No	Injury 28c. Injury at Work? 28d. Describe how injury occurred
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	ion	ctor: A y the fu	ation	2 Accident Investigation Jan 2, 2008 1409 hrs	1 Yes 2 V No
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	Divis	rs arter ral Dire	ertific	Suicide Could not be determined (Specific) Hetal/Metal	or Town, State)
296. Signature and title of certifier O.C.M.E. January 3, 2008 30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimbre, MD 21201 State 31. Date filled (Mannin Pay Year) 296. License number 296. License number 297. License number 297. License number 298. Signature and title of certifier O.C.M.E. January 3, 2008	he Hosp	in 24 not he Fune pletely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrence of the control of the cont	urred at the time, date and place, and due to the cause(s) and manner as stated. ation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Pay Year) 2008 32 registrar's Signature	Tot	To t	Med	and manner stated.	
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month Pay Year) 2008 32 degistrar's Signature	10			J.M. It	O.C.M.E. January 3, 2008
State 31. Date filed (Manth Day Year) 2008 32 kegistrar's Signature					enn Street, Baltimpre, MD 21201
Registrar OHI 0 1 2000				31. Date filed (Month, Pay Year) 2008 32 registrar's Signature	w.E.)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROY ALBERT HAMMEL **JANUARY** 10 2008 10:11 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 → M 2 ☐ F 195-42-0049 1950 Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "nature." any injury or other traumatic excessions. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2XXXX Maryland Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8140 Claborine Drive 21702 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐ Yes X☐ No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Design Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Edgar Hammel, Sr. Mary Gertrude Wentz P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Donna Kay Hammel, wife 8140 Claiborne Drive, Frederick, MD 21702 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Smithsburg Crematory Jan. 14, 2008 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liq 22 Keeneyorand FBasford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MY Caralar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in any, leading to in it adiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) physician a attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should 1/10 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes 2□ No Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After ! 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: n 24 hours after death.

ne Funeral Director: A pletely filled in by the fu within 2

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Ashwal, M.D., State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

56 Thomas Johnson Drive, Frederick, MD 21702 32 Registrar's Signature

M

29c. License number

29d. Date signed (Month, Day, Year)

JAN 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 05 Robert Lee Hammond /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Wicanic Paional Medical Year | If Under 24 Hr If Linder Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 XM 2 □ F 216-56-0815 Director Delaware 10-10-1950 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 X Yes 2 No Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 items 23a death v 607 Clyde Avenue 21826 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married than "natural", or 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 is marked other the any Injury or other traumatic event, the angle of the property of Driver Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Hammond Jeannette Wooters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Walston - Personal Rep. 607 Clyde Avenue, Fruitland, Maryland 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva Delmar, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner reumonia Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical as attending [IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 kmUnknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ No 24a. Was an page 2 autopsy performed 2 No Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 ☐ Yes 2 No 1 Minpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Iniury 1 ☐ Yes 2 ☐ No after death Director: completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

thin 24 hours at To the within

State Registrar

Medical

29a. Certifier

enni

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

and manner stated.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

V-2				epartment of Health and N Certificate of Death	lental Hygiene	008 01370
	Physici /Media		1. Decedent's Name (First, Middle, Last) Laura Marie Johns	5	2. Date of Death Month 12, 200	3. Time of Death 7:20pm M
	Examir	er	4a. Facility Name (If not institution, give street and number) Mariner Health of Glen Burnie	4b. City, Town, or Location of Death Glen Burnie		ounty of Death nne Arundel
	uneral irector		5. Social Security Number 213-22-3513 6. Sex 1 M 2 M F 103 Y	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Apr 18, 1904	9. Birthplace (State or Foreign
Maryland	r-f show fied at	lor	10a. State 10b. County 10c. City, Town	or Location len Burnie		10d. Inside City Limits 1 x ☐Yes 2 ☐ No
with the	3a or 28a it be notif	Funeral Director	10e. Street and Number 7355 Furnace Branch Road	10f. Zip Code 21061	10g. Citize	on of What Country?
036 urs after death	al", or items 2 xaminer mus	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever In U.S. Armed Forces? 1 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	Bace - American Indian, Black, White, etc.
Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Important if them 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of worki life. DO NOT use retired) memaker	ng	of Business/Industry Home
/land	rked othe	To Be C	17. Father's Name (<i>First, Middle, Last</i>) Phillip Long		(First, Middle, Maiden St. (Westbrook)	
, Maryla and 2 should be alth and Mer	n 27 Is ma er trauma		19a. Informant's Name/Relationship (Type. Print) Ruth House daughter	Mailing Address (Street and Number or Rure 1975 NoIcrest Road	al Route Number, City or T Glen Burn	own, State, Zip Code) ie MD 21061
imore Pages 1	ant: If iten ury or oth		1 ∯Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	crematory or other place)		ntion - City or Town, State Mberland MD
Balti permit.	Import any inj once.		21. Signature of Futeral Service Licenses	^{22. Name} 3% मिलिल र्मानिश्रिया Hon 108 Virginia Avenue:	Cumberland, MD	21502
/M	sician ledical aminer		23a. Part1. Enter the disease, of complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of the conditions of the caused the death. Do no shock, or heart failure. List only one cause on each line. Due to (or as a consequence of the caused the death. Do no shock, or heart failure. List only one cause on each line.	ge Demente		Approximate Interval Between Onset and Death Hew Years
8760, state be executed	physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of our consequence our consequence of our consequence of our consequence of our consequence our consequence of our consequence of our consequence of our consequence our consequence of our consequence our consequence of our consequence our consequence our consequence our consequence our consequence our consequence of our consequence our consequence of our consequence our consequence of our consequence our consequen			
I Records, P.O. Box 68760, The law requires that the death certificate be executed	attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ⚠ No 9 ☐ Unknown 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	230	d. Date of delivery Month Day Year
rds, F quires tha	been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco use 1 ☐ Yes 2271	contribute to the cause of death? No 3 Probably 4 Unknown
	ate has	Completed			24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Or Vil Physicia	this certiral directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	TO IValishing Flor	ne 5 ☐ Residence 6 ☐	
DIVISION OF al or Attending Phys after death.	To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	1 ☑ Natural 5 ☐ Pending investigation 3 ☐ Suicide 4 ☐ Homicide	ury Work? M 1 □ Yes 2 □ No	28d. Describe how injury o 28f. Location (Street and N City or Town, State)	Vumber or Rural Route Number,
he Hospit n 24 hours	he Funera pletely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, of the basis of examination and/or and manner stated.	leath occurred at the time, date and place, a prinvestigation, in my opinion, death occurr	and due to the cause(s) and ed at the time, date and pl	id manner as stated. ace, and due to the cause(s)
To t	Tot	Σ	29b. Signature and title of certifier decirculative of the Marketing Physician	29c. License number DODQSS7	3 011	signed (Month, Day, Year) 15/2008
	V		30. Name and address of person who completed cause of death (Item 23a) (Ty	3 HOSPITHL DR,		
	Stat Registra	-	31. Date filed (Month, Day, Year) JAN 2 3 2008 32. Registrar's Signature	Joach		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 0050 25 08 BARRY LOUIS **JESTER** /Medical 4c. County of Death Wichnieco Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner alisbury Kegional Medical Center 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1**%** M 2□ F Months Days Hours Min. 212-72-1436 Director 25,1965 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1 Yes 2 No Director MD STOCKTON WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21864 USA 601 SNOW HILL ROAD by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If them 27 is marked other them any Injury or other traumments. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 SALES MANAGER BEVERAGE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY CATHERINE GREEN ၉ ROBERT LEWIS JESTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARI WEBB JESTER (WIFE) SNOW HILL RD., STOCKTON, MD 21864 601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) W. 1/8/2008 JOHN TAYLOR TEMPERANCEVILLE, VA uneral Service Licensee 22. Name and Address of Facility THORNTON FUNERAL HOME, INC. 24183 CHADBOURNE ST-PARKSLEY, THORNTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical consequence of): Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed and resulting in death) Last Division or Vital Records, P.O. Box 68760, physician s the burial by Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown antributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No nea 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 No 1 ☐ Yes Other: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after decreix Atr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I completely filled 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Koza D006071> 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) salisbury WD SISO East

State Registrar

31. Date filed (Month, Day, Year)

Jalali

32. Registrar's Signature

2008

100

Corroll ST

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 0 9 200 g James F. Jones /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner esdic o.nt ISDURU VICOMICO 8. Date of Birth (Month, Day, Year) FEB. 25,1942 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In vrs. last birthday) **Funeral** 1 → M 2 □ F Months Days Hours 212-40-8974 65 FEB. Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director MD Dorchester Federalsburg 1 ☐ Yes 24 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r 21632 United States 5831 Davis Mill Pond Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11, Marital Status Black, White, etc. 1 Yes 21 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White 2 3 ☐ Widowed 4X X ivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator Construction 1017. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. Jones Jeanette E. Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 955, Hurlock, MD 21643 Tammy Clementson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages . tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Unity-Washington 01/14/08 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

W. Juel 7 22. Name and Address of Facility Framptom Funeral Home, P.A. Muheel ysken 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MENINGION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SRIZURR THE ALTABLE Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physiclan: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) the þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes No 3 Probably 4 Unknown Completed cate has by page 2 s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑00 autopsy performed? certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Department ျှ 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural (Month, Day Year) n 24 hours after death.

le Funeral Director: At bletely filled in by the fun 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To th. within 2.

State Registrar 29b. Signature and title of certifier

6-Hustin

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WARY

COMSTAL

DHMH 17 Rev 1/2001

29c. License number

00053410

29d. Date signed (Month, Day, Year)

10 BOK 1733 SALIS BURY NO 2822

108

ames Jone

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 1, 2008 ear 2129 Richard J. Kahn 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) 945 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 XM 2 ☐ F 62 Montana 217-42-0984 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Potomac Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 U. S. A. 11100 PotomacCrest Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No White Specify: Specify. 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banker Mortgage 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flora Schecter Marvin Kahn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 242 Red Run Road, Oakland, Maryland 21550 Robin R. Moreau - Ex Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Garden of Remembrance 1/4/2008 Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Edward Sagel Funeral Direction, 1091 Rockville Pike, Rockville, Inc. Maryland Donald (20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Exsanguination Due to (or as a consequence of): Hours Gastrointestinal Hemmorrage Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectonic pregnar Month Day Year 23e. Did tobacco use contribute to the cause of death? art I 25. Was case referred to medical examiner? 26. Place of Dear Other: 4 \(\text{Nursing H} \) 1 ☐ Yes 2X No 2 KER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner burial-tran law requires that the death certificate

Ö

Δ.

Records,

Division or Vital Hospital or Attending Physician:

Be Certification: To

been signed by

has

within 24 hours after death To the Funeral Directors

Examine

Physician/Medical

þ

Completed

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

a or

ms 23a

"natural", or items

permit. Pages 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natu any injury or other traumatic event, the Medical once.

Director

Funeral

Completed by

Be

ျှ

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	5 Other (specify)
Part II. Other significant condition	s contributing to death but not resulting in t	he underlying cause given in F

(Month, Day Year)

	1 ☐ Yes 2 ☐ [No 3 ☐ Probably	4 🛣 Unknown
	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy fin prior to completio death? 1 ☐ Yes 2 🎇 N	
th (C	Check only one)		
ome	e 5 ☐ Residence 6 ☐	Other (Specify)	
280	d. Describe how injury o	occurred	
28f	f. Location (Street and N City or Town, State)	lumber or Rural Rout	e Number,

Certification	1 🏻 Natural 2 □ Accident 3 □ Suicide 4 □ Homicide
edical (29a. Certifier (Check only one)

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 ☐ Pending investigation

6 Could not be determined

29c. License number

D31027

1 ☐ Yes 2 ☐ No

29d, Date signed (Month, Day, Year) January 1, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. P. Obrian 8600 Old Georgetown Road, Bethesda, Maryland

State Registrar 31. Date filed (Month, Day, Year) JAN 0 7 2008



Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month .48 Unnary 2008 Catherine H. Kaplanis /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 24,1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 X F Oklahoma **Director** 487-30-8084 78 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show Director 1 X Yes 2 □ No MD Prince George's Bowie ムアドイイト altimore, Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 2 Funeral 2916 Brierdale Lane 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Department of Health and Mental Hygiene, important: If item 27 is marked other than "natural" or iter anny injury or other traumatic event, the Medical Examiner anny injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Francis Hobart Catherine Clara Acosta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John N. Kaplanis / spouse 2916 Brierdale Lane Bowie, MD. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 01/06/2008 Alexandria, VA. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 20715 6512 NW Crain Hwy. Bowie, MD. 8 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician eritoni disease or condition resulting in death) /Medical ue to (or as a consequence of): ruction with Perforation' Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) ed by the a signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

02/10 31. Date filed (Month, Day, JAN 0 7 2008

29b. Signature and title of certifier

30. Name and address of person



who completed cause of death (Item 23a) (Type, Print)

29c. License number

LUCK Rd

mD 5 2 500

29d. Date signed (Month, Day, Year)

008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 ea ам 6:45 Karen Marie Ketterman January 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days March Day 1 3 1959 1 □ M 2 🗷 F 48 212-82-3903 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov dical Examiner must be notified at Westminster 1 ☐ Yes 2 No Carrol1 MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA 3571 Cemetery Lane **Funeral** within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled we Department of Health and Mental Hygien Important: If flem 27 is marked other that any injury or other trainment. Claims Manager Wal-Mart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lundy Blevins Gladys Anderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Otis L. Ketterman/husand 3571 Cemetery Lane Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 01/08t/2008 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Memorial Gardens Finksburg, MD 4 ☐ Donation 5 XOther (Specify) 21. Signature of uneral service Licensee Printed AdmeradiivHome and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent premant 3 □Ectopic pregnancy ō in the past 12 pon 1 Yes 2 No Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown 9 Unkpown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use conribute to the cause of death? 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 The certificate Yes 2[To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 110 Other: 4 Nursing Home 5 Residence 1 Yes 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 6 🗆 After thi funeral c 28a. Date of Injury (Month, Day Year) 27. Manne of D 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name an ddre

of pers

2008

DESTHILDTER, HD 21157

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Amend Item 25 per verb., g876; 62401.608 with the 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Henry Eldridge Krueger 2008 6:14 A M JAN. 02, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 32858 Downing Road Delmar Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov. 18, Nov. 18, 9. Birthplace (State or Foreign 5. Social Security Number 6 Sav 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 82 Maryland 215-20-0206 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 □ Yes 2X □XNo MD Director Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32858 Downing Road 21875 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify: þ 3 Widowed WDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waterman Fishing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Krueger Geneva Marvel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32858 Downing Road, Delmar, MD 21875 Kathy Lutz/Granddaughter injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State East New Market Cem. 01/04/08 East New Market, 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Framptom Funeral Home 21. Signature of Funeral Service Licensee RECoule 216 N. Main St., Federalsburg, MD 21632 CFSP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hears **Physician** congestive /Medical Due to (or a a consequence of): Examiner Coranocy oute Sequentially list conditions, if any find list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con sequence of) Examiner Due to (or as aconsequence of): physician requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) a∏Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an The law autopsy performed? Yes 2 No certificate 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

P.O. Box 68760 Division or Vital Records,

the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this

Certification:

Medical

29a. Certifier

(Check only one)

1 Natural 2 ☐ Accident 3 Suicide 4 ☐ Homicide

29b. Signature and title of certifier

6 Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

0059931

1 ☐ Yes 2 ☐ No

1-08-08

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cal ise of death (Item 23a) (Type, Print)

HOTMANN LARIES 31. Date filed (Month,

30434 MT. VERNUN Rd. PRINCESS ANNE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear **Physician** Month 0 2008 VNISE)Anuary 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner tmore niversit MD If Under 1 Year | If Under 24 Hrs. | 8. Months Days Hours Min. 7. Age (In yrs. last birthday) 36 Yrs. Date of Birth (Month, Day, Year) 10/14/1971 Social Security Number 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Country) MD 217-70-0596 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at BERKELEY Director MARTINSBURG 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 58 CAYMAN CT. 25404 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDERICK GRIM MARIA BAUGHMAN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID L. KING JR. / HUSBAND 58 CAYMAN CT., MARTINSBURG, WV 25404 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 01/15/2008 CEDAR LAWN CEMETERY HAGERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN FUNERAL HOME BOX 821 21. Signature of Funeral Service Licensee Broun M. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** dai /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any leading to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of) Box 68760. attending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Į0 in the past 12 months? Month Day Year 4☐ Pregnant at time of death 9☐ Unknown 5 Other (specify) signed by the a P.0. 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 nknown peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 has certificate diabetes mellitus 1□ Yes 2 No Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Mo 1 Impatient 2 ER/Outpatient 3 DOA 1º this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: After (Month, Day within 24 hours after usus... To the Funeral Director: Aft 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Wedical (Check only one)

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who

Montgome

29c. License number

29d. Date signed (Month, Day, Year) Anuary 10, 2008

and manner stated.

ompleted cause of death (Item 23a) (Type, Print)

Greene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Ellen Taylor Kerley 01 02 08 1854 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner gional medical Len NICOMICO 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 M F Months Hours 215-26-4404 80 Director March 10, 1927 Delaware Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1X Yes 2 No Director MD Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 109 Bacon Street 21837 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify. 3 Widowed 4 □ Divorced Year or Dates "natural", white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Clerk Convenience Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked B. Clyde Cooper ၉ Julie E. Owens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Kerley (Son) P.O. Box 51 Mardela Springs, MD 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Melson's Cemetery Jan. 6, 2008 Delmar, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Kwill. 13 East Grove Street Delmar, Delaware 19940 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or in the disease, or complications that caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eb. /Medical Due to for as a consequence of) Examiner Keral to Sequentially list conditions, if any, leading to immediate causs. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Jivision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy death? 1 ☐ Yes performe 2 No or Attending Physiclan; 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes PNo 2 ER/Outpatient 3 DOA 2 After this funeral 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation **U** Natural death. 1 ☐ Yes 2 ☐ No 2 Accident fter death the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospitallo within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

completely

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

2008

SHORE

32. Registrar's Signature

DR

EASTERN

JAN 0

State Registrar SALISBURY

29c. License number

MD. 21804

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIPM 24a perVERB. C875 1/22/08 WS.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Z 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2008^{ea} Betty Jane Kasa January 7:40 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Care and Rehabilitation Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 □ M 👷 🗆 F 84 Director 215-14**-**1112 10/06/1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at 28a-f sh notifled ∏Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or mimortant: If item 27 is marked other than "natural" or items 23a or any Injury or other traumatic event, the M-dical Examiner must be ano. 201 East 5th Street 21701 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2√2 No Specify. Specify: white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Charles Herbert Eppley <u>Bessie Jane Marshall</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7045 Basswood Rd., Frederick, MD 21703
Date 20c. Location - City or Town, State John E. Wilcox, Jr./halfbrother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gardens 1/10/08 Frederick, Maryland 22. Name and Address of Facility
Keeney and Basford PA Funeral Home
106 Fast Church St., Frederick, MD 21701
Approx 21. Signature of Funeral Service Licensee MO1222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 1 Natural al or Attending Plater death. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral D 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. To the 29b. Signature and titl of certifie 29c. License number 29d. Date signed (Month, Day, Year) January 8, 2008 2 Freduiel, Mr. 21701 person who pleted cause of death (Item 23a) (Type, Print) 0 32. Registrar's Signature State

Registrar

DHMH 17 Bev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 14, 2008Sadie Virginia Lawson 12:50р м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8202 Elm Lane Chesapeake Beach Calvert 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 26,1928 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 💢 F Maryland 79 216-22-3460 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Calvert Chesapeake Beach 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8202 20732 ElmU.S.A. Lane Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 2 Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 Is marked other tf meat weigher & wrapper grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Lawrence A. Grierson Sara Iola Phipps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold L. Lawson, son 26290 Tin Top School Rd., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State So. Memorial Gardens 01-17-2008 Dunkirk, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). burial-transit and Due to (or as a consequence of): the attending physician hed for use as the buria be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown Day 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 148ART FAILURE CONGESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an sate has page 2 s autopsy performed? Ves 22 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🗷 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: tely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 h To the Fu and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 40370 January 15, 2008 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter L. Wisniewski, M.D., 110 Hospital Rd., Suite 310, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Elvira Lora рм January 2008 4:00 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🐷 F 097-40-2738 May 17, 1919 Colombia . Usual Residence of Decedent 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☑ No Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3333 University Blvd, West 20895 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify.Colombian YYes 2□ No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary O.A.S 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francisco Paula Florez Elvira Caro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11315 Woodson Avenue, Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan. 5, Metropolitan Crematory Alexandria, Virginia 2008 d Funeral Service Licens 22. Name and Address of Eaclity Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, MD 20901

Luis Lora/Son 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arrhythmia Due to (or as a consequence of)

Approximate Interval Between Onset and Death

Hours

Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician

/Medical

Examiner

10a, State

Funeral

Director

show

28a-f

a or

r than "natural", or items 23a the Medical Examiner must t

72 hours after

d 2 should be filed with and Mental Hygier
7 is marked other th . Pages 1 and 2 should be filed w fment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, th

permit. Pages Department of Important: If it any Injury or o

Physician

/Medical

Examiner

and burial-tran

physician

the by

the as attending

use

ģ

pe

has e 2 s

His funeral dir

After

death.

n 24 hours after death.

ne Funeral Director: A

oletely filled in by the fi

the To the within

npletely

Hospital or Attending

page certificate

executed

that the death certificate be

Box 68760

P.O.

Division or Vital Records,

Examine

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

Maryland 21215-0036

altimore,

notifled at

Director

Funeral

ò

Completed

Be ပ္

> Acute Myocardial Infarction Due to (or as a consequence of): Pneumonia

Days Days

Due to (or as a consequence of):

Dementia

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

and manner stated.

severe Spinal Stenosis, Bradycardia

23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 Unknown

24a. Was an performed? Ves 214 No autopsy 26. Place of Death Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

Hospital: Impatient 28a. Date of Injury (Month. Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

29b. Signature and title of certifier

27. Manner of Death

Natural

2 ☐ Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month. Dav. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIFRE

5 Pending

investigation

6 Could not be determined

MD D55054 PhI

Attan Kasid, GM.D. SUITE 409 GAIT THERSBURG SUITE

MD 20877

State Registrar 31. Date filed (Month, Day, Year)

JAN 0.7

			1-	For State Registrar			State of	f Maryla			nt of H			lental Hy	giene Reg. No	O 51 1	38	01	383
	Physic /Medi Examir	cal		David	P. W.	Li		nber)		4b. City	, Town, or	Location		2. Date of De Month January	7 3 ^{Da}	y 2008		3. Time 0	of Death
Newson Newson	Funeral Director		5. S	Suburba ocial Security 138–44- al Residence	-4361		M 2□F	7. Age (In yr. 7 8	s. last birthday, Yrs.	Bethe If Und Months	er 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da June 20	th	Montg 929		ace (State	or Foreign
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be Completed by Funeral Director	10a Mi 10e	State aryland Street and N 6005 Marital Status Never Mail Widowed (Special Special Sp	umber Filden Tilden Tilden Tilden Tilden Tilden Tried 2 Maritan Amerikan Amer	M Lane ried 1: ried tt's Educe st grade Last)	Armed For 1 Yes, Giv Year or Dation completed) College (1 2	dent Ever in ces? 2 12 No et les:	U.S. 13.	Nocky 10f. Z Was Dec If Yes, sp 1 Yes dent's Us kind of w DO NOT	edent of Hisecify Cubar 2 12 No ual Occupa ork done d use retired)	Specify: ation uring most 18. Mothe Chow	r's Name Ju	ecify Yes or No Rican, etc.)	16b. K	SpecifyAsian 16b. Kind of Business/Industry Import/Export Maiden Surname)			
Baitimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		20a.	Eleanor Method of Dis 1 Burial 2 4 Donation	C. Li	1/Wi: 3 □Re	fe	State	Place of Dispo cemetery, cre- tropol:	osition (Namatory or itan 2. Name a	rilder replace Crema nd Address S J.	atory	Jan 2	ockvill uary 5, 008 Funeral	200. Lo	MD 20 cation - Ci kandr: ne Inc	ty or Tov	wn, State Virgi	.nia
k E	Cate be executed hysician and the burial-transit the burial-transit	dical Examiner	Seq if an caus Caus that	Part1. Enter shock, or he lediate Cause asse or conditi-liting in death) uentially list or, leading to its. Enter United se (Disease of initiated event lting in death)	on onditions, mmediate erlying rinjury s	b.	Resp Due to (c	irator or as a conse	y Failu quence of): Pneumo quence of):	er the mo	de of dying	g, such as	cardiac o	, W , S	rest,	er Sp	6	Approximal Interval Be Onset and Days	tween Death
O. DOX O	t the death certific by the attending p ached for use as	Physician/Med		EMALE: Was deceder in the past 12 1 Yes 2 9 Unknowr	2 months? □ No	230	1□Live bi	ome pf pregr rth 2 ☐ Fet int at time of wn	al death 3	Ectopic p	regnancy pecify)				2	23d. Date o		,	Year
מו חפכטומא, ו	Attending Physician: The law requires that the death certificate be executed and each. If cerors, After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by P	Part	II. Other signi	ficant condition	ons contr	ibuting to dea	ath but not re	sulting in the u	nderlying	cause giver	n in Part I.		24a. Was a autop perfor	es 2xx	No 3	Proba	sy findings	Unknown
DIVISION OF VIK	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be	27. N 1 2	Vas case refe xaminer? Yes 2 Manner of Dea Natural Accident SUicide Homicide		ation	28a. Date or (Month)	Injury , Day Year)	ER/Outpatien 28b. Time of Injury ome, farm, str	М	Other Other Other Other Other Other	4□ Nur	sing Hon 2	(Check only or ne 5 ☐ Resid 8d. Describe h 8f. Location (S City or Tow	ence 6 ow injur	y occurred			nber,
e	To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A completely filled in by the fi	Medical	29b.	· a	title of certifier	1	r: On the bas	sis of examin	owledge, death	vestigation	at the time n, in my op c. License DO 71	inion, deat	d place, a		date and	and manni place, and e signed (Mary 3	d due to t	the cause(s lay, Year)	s)
7	Stat Registra	e	A1	len Nin	metz, Math, Day, Year)	D	32 4 Re	530 W		n Av		#730	, Ch	evy Cha	ase,	MD 2	0815	5	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryland		rtment of H			giene Reg. No.	801	01384
	Physici		1. Decedent's Name (First, Middle, Last)	LARBICK	,			2. Date of Dea Month JANUS	Day	Year 2002	3. Time of Death 8 11:05 f. M.
	/Medic Examin		4a. Facility Name (If not institution, give		Suns	4b. City, Town, or		Death RNIS	1	unty of Death	
Ī	Funeral Director		5. Social Security Number 6. Security Number 15. Security Number 6. Security Number 15	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24		h y, Year) 1927	9. Birth Con Deer	nplace (State or Foreign untry) Park, MO
	aryland show	70	Usual Residence of Decedent 10a. State 10b. County		, Town or Loc	ation					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the M or 28a-f	Director	Maryland Prince C	eorge's A	delphi	10f. Zip Code			10g. Cîtizen	of What Co	untry?
	s 23a	erail	11010 Cherry Hill	Road 12. Was Decedent Ever in U.S	3 13 W		0783	n? (Specify Yes or No-	. 14.	USA Race - Amer	rican Indian.
920	72 hours after death with the Maryland 'natural', or flams 23a or 28a-f show dical Examinar munt be nailliad at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	į	Yes, specify Cuba ☐ Yes 2፟ ☐ No	Specify:	n? (Specify Yes or No- Puerto Rican, etc.)		Black, White	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygene. If item 27 is marked other than "naturat", or frams 23e or 28e-1 show or other freumatic event, In a Madical Examinar man be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give k life. D	ent's Usual Occup ind of work done of O NOT use retired	during most o i)	f working		of Business/l	
2	filed wi Hygien other th		17. Father's Name (First, Middle, Last)	4	Medi	cal Secr		Name (First, Middle,		tors O	ifice
Maryland	uld be i dental l irked o	To Be	Truman Mosser					ora Specht			
Many	2 should to and Ment is marked reumatic e		19a. Informant's Name/Relationship (Ty					or Rural Route Numbe	-		
e,	1 and 2 Health tem 27		Alan D. Larrick - 20a. Method of Disposition	20b. Pla	ace of Dispos	ition (Name of		d., Adelph		2078 ion - City or	
E E	Pages nent of int: # ii		1 ☐ Burial 2X Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		atory`or other plac tan Crema		6/2008	Alexa	ndria	, Virginia
Baltimore,	permit. Pages 1 and Department of Healt importent: if item 2 any injury or other ance.	_	21. Signature di Funeral Service Loe	who MOIH		Name and Address		Home, P.A.			more Ave. e, MD 20781
	Physician		234. Part1. Enter the disease or compleshook, or heart failure. List only of the disease or condition.	ne cause on each line.	Do not ente		ng, such as ca	rdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ		· · · · · · · · · · · · · · · · · · ·					
	led nsit	Examiner	Sequentially list conditions, any, loading terminopolation and terminopolations. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ianda of):						
8760,	icate be executed physiclen and s the burial-transit	dical Exar		Due to (or as a consequ	ience of):						
.O. Box 6	death certif e attending od for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnar 1	death 3 🗆	Ectopic pregnancy Other (specify)	′		23d.	. Date of deli	ivery Day Year
rds, P	es be	by	Part II. Other significant conditions con HYPZRTENSION		ılting in the un	derlying cause giv	en in Part I.		obacco use d Yes 2□N		o the cause of death?
Vital Records,	w S S	Completed	HYPERLIPED.					24a. Was	SV	prior to d	itopsy findings available completion of cause of
al B	Th ate pag	_	SEIZURE DO	SORPER				1 ☐ Yes	rmed? 200 No	death?	2 🗆 No
of	ding Phys h. After this funeral dii	tion; To Be	25. Was case referred to medical examiner? 1 Yes 21 No		ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: urs	ing Home 5 Residuel R	dence 6 🗆		cify)
Division	io Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify,	me, farm, stre	et, factory, office		28f. Location (S City or Tov	Street and N vn, State)	umber or Ru	ural Route Number,
	24 h Fur etely	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death ion and/or inv	occurred at the tir estigation, in my o	me, date and pinion, death	place, and due to the occurred at the time,	cause(s) and date and pla	d manner as	s stated. to the cause(s)
)	To the within 2 To the complei	Me	29b. Signature and title of certifier	5/1)	10	29c. Licens	number	519	29d. Date si	gned (Monti	h, Day, Year) 4 200 X
0	(5)		30. Name and address of person who con RICHARD E F	ompleted cause of death (Item	23a) (Type, F	Print)	10/	12 A 15	12	-(-	75 2133/
	Sta	to	31. Date filed (Month, 2008ar)	15 H E 12 4	710 /	ENNIN	16 to	JIN	DAL	MOI	CE 61666
	Registr		JAN U 7 ZUUD	32. Registrar's Signat	ere?						

	1.	State Amend#7.PerFH. Decedent's Name (First, Middle, L.		U e	rtificate of	Deaill		2. Date of Dea	ath Day	Year	3. Time of Deat	h
cian ical		ARNOLD WE	SLEY LAIDIG, JR					JANUARY	01,	2008		Y _M
iner	4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL BALTIMORE CI								4c. Co	ounty of Dear	th	
ı			Sex 7. Age (In yrs. la	st birthday)	If Under 1 Yea	r If Under 2	24 Hrs.	8. Date of Birt	h .	9. Bir	thplace (State or Fore	əign
		84-54-9160 sual Residence of Decedent	¹ M ² F 63 64 64	Yrs.	Months Days	Hours	Min.	(Month, Day MAY 7,			WA	
	177	a. State 10b. County		Town or Le							10d. Inside City Lin 1 X Yes 2 □	
Funeral Director	10	le. Street and Number	ALE	AANDK	10f. Zip Code				10a Citizer	n of What Co		
j		6306 MANCHESTER	WAY		22304				U.S.A			
nera	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Ye Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,							cify Yes or No- Rican, etc.)	- 14.	. Race - Ame Black, Whit	erican Indian,	
2		1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No						HITE	
Completed		15. Decedent's l (Specify only highest g	rade completed)	16a. Dece (Give life.	edent's Usual Occi e kind of work don DO NOT use retir	upation e during most red)	t of workir	ng	16b. Kind	of Business	/Industry	
		Elementary/Secondary (0-12)	College (1-4or 5+) 5+	OFF	ICER			ļ	U.S.	ARMY		
Be	17	7. Father's Name (<i>First, Middle, Las</i> ARNOLD LAIDIG	st)					(First, Middle, FOWLER	Maiden Su	urname)		
ToB	1	9a. Informant's Name/Relationship JUDY M. LAIDIG	(Type. Print) WIFE	1	ing Address (Stree	et and Numbe	er or Rura	al Route Numbe				
-	20	Da. Method of Disposition	CO	ace of Disp emetery, cre	osition (Name of ematory or other p	lace)	D	ate	20c. Loca	ition - City or	Town, State	
		ARLINGTON NATIONAL CEMETERY 3/5/08 ARLINGTON									, VIRGINIA	7
	2	1. Signature of Funeral Service Lic	ensee	- 1							VA 22314	
	lr d	3a. Part1. Enter the disease, roshock, or heart failure. Lis mandiate Cause (Final isease or condition sesulting in death)	replications that caused the death, y one cause on each line. DIFFUSE FUNG.	. Do not en	ter the mode of d						Approximate Interval Between Onset and Death 1 WEEK	1
		4	b. Due to (or as a consequence of the consequence o	SSION	AND NEU	TROPEN	IA				3 WEEKS	
Examiner	Ci Ci	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events sulting in death) Last	TREATMENT OF	ACUT	E MYELOG	ENOUS	LEUK:	EMI A			1 MONTH	
ical		Salary Land	Due to (or as a consequence of the consequence of t		ODYSPLAS	TIC SY	NDRO	ME			2 YEARS	_
Physician/Med	IF 2	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnar □ Other (specify)				230	d. Date of de Month	elivery Day Year	
2		art II. Other significant conditions	contributing to death but not resul	lting in the u	underlying cause (given in Part I.		23e. Did t			o the cause of death	
Completed								24a. Was		24b. Were a	utopsy findings availa	able of
l e									rmed?	death? 1 □ Ye	_	
ag ag	2	5. Was case referred to medical examiner?	Hospital:		[c	thor:		(Check only o				
on: To	100	1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of 28c. In	jury at lork?	1	me 5 Resi 28d. Describe			ecify)	
Certification:		2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e Place of injury - At hor	me, farm, si		□Yes 2□ e		28f. Location (City or To		Number or F	iural Route Number,	
C												
Medical												_

PARTIES AND PROPERTY.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 3:10 A M 03, 2008 Jan John R. Larkin, Jr. /Medical 4c. County of Death
Anne Arundel 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis 612 Admiral Drive, Apt.384 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days 87 220-05-2318 Jul. 26,1920 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No MD Director Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 612 Admiral Drive, Apt. 384 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1√2 Yes 2 No 1942— If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 ☐ Divorced 1945 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) National Security Agency Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John R. Larkin, Sr. Alma Andrew 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 614 South Taylor Street Arlington, Virginia 22204 John R. Larkin, III/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Jan. 08, 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. Crownsville, Maryland 2008 22. Name and Address of Facility 21. Signature of Puneral Service License Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician lo yr YROSTATE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s autopsy 2 XNo 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one Be examiner' 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this : After thi 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27 Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: d in by the f 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after to the Funeral Discombletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) long DR, Armondis, HD 21401 TIDEWATER 31. Date filed (Month, Day, Year) State JAN 0 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day IRENE 01 LOAR 06 2008 2030 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) Birthplace (State or Foreign Country)
 West Virginia **Funeral** Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 X F Director 214-52-1464 89 August 21, 1918 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 100 Honeysuckle Lane Apt. 206 Completed by Funeral 21532 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iter Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify 3 XWidowed 4 ☐ Divorced "natural", White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Kelley Williamson ဥ Grace Van Meter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is,
any Injury or other trau Mary McKenzie - Daughter 13516 New Georges Creek Road, Frostburg, Maryland, 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 09. 1 Burial 2 □ Cremation 3 □ Removal from State Potomac Memorial Gardens 4 Donation 5 Dother (Specify) 2008 Keyser, West Virginia 22. Name and Address of Facility Eichnorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licenses 8 East Main Street, Lonaconing, Maryland, 21539 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Ooset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day ned by the a 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No page 2 s autopsy performed 2 No 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 No 1 🗌 Yes 1 | Inpatient Certification: To 2 □ ER/Outpatient 3□ DOA this 5 Residence 6 □Other (Specify) funeral 27. Manner of Death 28a. Date of Injury After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural Injury 5 Pending М investigation 1 Yes 2 No 2 Accident the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: after death. 24 hours a the Hospital

filled in by within 24 hor To the Fune completely fi

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shiv Highway LAVAle, Maryland 21502 Shanna

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month, Day, Year) JAN 0 3 2008

			1 _ State	Department of Health and Mental Hygiene Certificate of Death	
	Dhyaiai		Registrar Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death	Ü
	Physici /Medio	al	Hattie Lee	JAN. 03, 2008 7:20 P	M
	Examin Funeral Director	er	4a. Fecility Name (If not institution, give street and number) Ruxton Health of Denton 5. Social Security Number 218-16-6803 6. Sex 1 M 2 F 7. Age (In yrs. last bit) 84	4b. City, Town, or Location of Death Denton Caroline thday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. FEB. 22, 1923 Maryland	ign
	land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location 10d. Inside City Limi	its
	e Mary 3a-f sh tifled	Director	MD Caroline	Denton 1 □Yes 24CM	No
	th with th 23a or 28 ust be no	ral Dire	10e. Street and Number 420 Colonial Drive	10f. Zip Code 10g. Citizen of What Country? United States	
5-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes X□ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White	
21215-0	within 72 heene. than "natu he Medical	Completed	(Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5-)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) memaker Own Home	
Maryland 2	0 = 0 \$	To Be Co	17. Father's Name (First, Middle, Last) Oscar Charles Currey, Sr.	18. Mother's Name (First, Middle, Maiden Surname) Mary Iva Figgs Speor1	
	and 2 shou saith and M 127 is mar er traumai			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1413 Laurel Rd., Laurel, DE 19956	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any Injury or other traumatic evonce.		M Burial 2 Cremation 3 D Removal from State cemete	Disposition (Name of ry, crematory or other place) a Cemetery 01/07/08 Vienna, Maryland	
Ball	permit Depart Import any Inj once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632	
*	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events 23a. Part1. Enter the disease, or complications that cause disease. Final part of the death. Do not cause on a consequence b. Due to (or as a consequence cause (Disease or injury that initiated events)	Onset and Death Hours	2
x 68/60,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	edical	Due to (or as a consequence d		
C. Box	the death certific by the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year	
ecords, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in		wn
r	The ate has page	Completed	DIABETES, JUZHEIMER'S	24a. Was an autopsy performed? 1 Yes 2N No 1 Yes 2N No 1 Yes 2N No 24b. Were autopsy findings available prior to completion of cause of death?	
VITAI	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	26. Place of Death (Check only one) tpatient 3 □ DOA Other: 4 Nursing Home 5 □ Residence 6 □ Other (Specify)	
on or	nding Phy th. : After this e funeral c	\vdash	27. Manner of Death 28a. Date of Injury 28b.	Time of njury M 1 Yes 2 No	
DIVISION	ial or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)	rm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral directors.	Medical ((Check only one) 2 Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
)	Mith To	2	29b. Signature end title of certifier ATENDING	29c. License number 29d. Date signed (<i>Month</i> , <i>Day</i> , <i>Year</i>)	
			30. Name and address of person who completed cause of death (Item 23a)	Type Print) BLOOMINGDALE AU FEBERALS BR6, MT	2
	Sta Registr		31. Date filed (Month, Day, Year) JAN 8 2008 32 Registrar's Signature	diself, a	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

e!	. 4	Phy /M	sici edic	
		Exa	min	er
	. 10			
	F	une	ral	
	D	irec	tor	
	land	wo	4	

item 27 is marked other than "natural", or Items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified a filed within 72 hours after permit. Pages 1 and 2 should be filed within 73.
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "ns any Injury or other traumatic event, the Medic once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and strans attending p ed by the signed t page 2 funeral director, this After t 24 hours after death, e Funeral Director: / completely filled in by

Division or Vital Records, P.O. Box 68760,

1. Decedent's Name (First, Middle, Last) 2. Date of Death January 3°, 2008° ar Benjamin Liss 3:17 A 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Rockville Shady Grove Adventist Hospital Montgomery 8. Date of Birth . Age (In yrs. last birthday) 9. Birthplace (State or Foreign MA Our: 'ry) 1 M 2 □ F Months Hours Min. May 15, 92 577-30-8819 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes 2 □ No Director MD Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 11420 Strand Drive #305 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Max Liss Minnie Cipkin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 Wisconsin Avenue #1409 Chevy Chase MD 20815 Fulton Liss - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1K Burial 2 □ Cremation 3 □ Removal from State Judean Mem. Gardens 1/6/2008 Olney, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction Inc 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart fallure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2☐No 3☐ Probably 4☐Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 NO 1 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yas shahr () W

State Registrar 31. Date filed (Month, Day, Year)

JAN 07 2008

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 390 State of Maryland / Department of Health and Mental Hygiene [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14 2008 Рм January 1443 Amelia B. Moody 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 246 Mackall Street E1kton Ceci1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Vear 1 □ M 2 💢 F 220-14-3109 82 March 21, 1925 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 246 Mackall Street 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard L. Hartmann Lucy B. Peterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) F. Gaylord Moody, Jr./Husband 246 Mackall Street, Elkton, MD 21921 20b. Place of Disposition (Name of cometery, crematory or other place)
Gilpin Manor
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State January 18. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkton, MD P.A. Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 21. Sign Jure of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Serere Malnutrition nonths Due to (or as a consequence of): Sequentially list conditions

Physician /Medical Examiner sicien and burial-trans Division of Vital Records, P.O. Box 68760. さ use as the

Physician

/Medical

Examiner

Director

Be Completed by Funeral

12

Funeral

Director

show

Hygiene. other then "naturel", or Items 23a or 28a-f shovent, the Modical Examinar must be notified at

death with the Maryland

Maryland 21215-0036

1 and 2 should be Health and Mental

permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 is. eny injury or other treu

signed by d this certificate After this funeral of To the Hospital or Attending within 24 hours after death.
To the Funerel Director: After s after dec.

and fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
IE EEMALE.		ctopic pregnancy hther (specify)		23d. Date of delivery Month Day Year
ltypertensio hyperlipid	ntributing to death but not resulting in the undinger of the configuration of the configurati	erlying cause given in Part I.	23e. Did tobacc 1 Yes 24a. Was an autopsy performed 1 Yes 2 2	24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical			eath Check only one	
1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3□ DOA Other: 4□ Nursing	Home 5 Residence	6 ☐Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	njury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sicien: To the best of my knowledge, death o ner: On the basis of examination and/or inve- and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occ	e, and due to the cause surred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
1	inger mo	D6590	2	1/15/08

MO 138 Cathedral Street, Elkton, MD 21921

DHMH 17 Rev 1/2001

State

Registrar

(BACE)

Golez

32. Registrar's Signature

& Gopez mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Carlo

2008

23

31. Date filed (Month, Day, Year)

08-00286 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Karen B. McCue State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 11, 2008 1133 hrs **Medical Examiner** Karen В. **McCue** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Maryland Months Hours Days Director 219-68-7733 49 10-02-1958 1 M 2 X F Vrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland Frederick tant; If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. Frederick Yes 2 X No e, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 90 Waverly Drive, Apartment Q204 21702 United States Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes Widowed If Yes, Give Year White 4 X Divorced Yes 2 X No specify. Specify: ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Transcriptionist Medical of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold E. McCue Mona C. Mackle 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doreene Weadock / Sister 101 Brookeridge Court, Timonium, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Pages 1 Resthaven Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State Januarv Frederick, Maryland mportant; Donation 5 Other Specify: 21. Signature of Funeral Service Licensee ²² Name and Address of Facility Reeney & Basford P.A. Funeral Home M01433 106 East Church Street, Frederick. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death a. Hanging Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause We (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED X AMENDED perME, C875, 1/23/08, WS Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) 5 for 1 Yes 2 No 9 V Unknown Unknown the signed by the I be detached f Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Ş Yes 2 ✓ No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has death? performed' ✔ Yes 2 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Other₄ Hospital: 1 / Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this ٩ 1 Yes 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject Jan 6, 2008 hanged self Natural 0000 hrs Pending Yes 2 V No To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 🗸 Suicide Could not be or Town, State) Frederick Memorial Hospital, Frederick, Md determined (Specify) Hospital Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 13, 2008

Registral
DHMH 17 Rev 1/2001

OCME 2006

State

Milver

Margarita Korell MD.

31. Date filed (Month, Day Yor)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kenneth E. McManus 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 2, 2008 KENNETH E. McMANUS JR. 1716 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Prince George's Hospital Center Cheverly 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign WASHINGTON Country) D. C. Months Days Hours Director JAN. 8, 1960 47 578-88-2123 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 YYes 2 No WASHINGTON D.C. notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20019 UNITED STATES 4423 KANE PL., N.E. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married 2 X No Yes BLACK 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced If Yes, Give Yea à 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Pages I and 2 should be filed within 72 hours nent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) other than "1 the Medical F LANDSCAPING LANDSCAPER Baltimore. MD 21215-0036 11th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Be SARAH BRAXTON <u>KENNETH E. McMANUS SR</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) other traumatic N.E. 4340 SHERIFF RD. #301 <u>DARLENE McMANUS / W</u>IFE WASH. D.C. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 tment o tant: 1/9/08 HARMONY MEM. PARK CEM. LANDOVER. / Donation 5 Other Specify 22. Name and Address of Facility ature of Funeral service Upensee DC 20002 N.E. WASH CAPITOL MORTUARY 1425 MARYLAN<u>D AVE</u> complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart on each line. Approximate Interval 23a. Part I. Enter the d's ase, o **Physician** Between Onset and failure. List only be cause on each line. M_dical Death Neck injuries complicating hypertensive atherosclerotic cardiovascui Immediate Cause (Final disease :xaminer or condition resulting in death) disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical attending physician or use as the burial -X UNPENDED X #ENDED 7, 28a-f, perME, g877, 3/3/08 TT / #1, perME, g877, 3/3/08 TI The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed? death? ✔ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical æ Other₄ Hospital: examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 ✓ ER/Outpatient 3 1 🗸 Yes No within 24 hours after death.

To the Funeral Direction places. 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Natural Yes 2 y No Pending subject assaulted Jan. 2. 2008 4:21 pm Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State)
4423 Kane Pl. Washington, DC determined (Specify)

State

Zabiullah Ali, M.D. 1. Date filed (Month Dan Sear)

29b. Signature and title of certifie

4 X Homicide

29a. Certifier 1

one)

Medical

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 32. Regil rar's Si

and manner states

other-scene

29d. Date signed (Month, Day, Year)

January 3, 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Registra

		For State Registrar		Stat	e of Ma	aryland	d / Depa <i>Cer</i>			ealth a Death		ental Hy	gien Reg. No	201	38	0 1	393
DI		1. Decedent's Nam										2. Date of De			ear	3. Time	of Death
Physic /Med		Linda J	ean McLe	an							J	anuary	7 5,	2008		11:05	A M
Exami	ner	4a. Facility Name (nd number)			4b. City,	Town, or	Location	of Death			c. County of			
	100	5236 Wes 5. Social Security f	tpath Wa	Sex	7. Age	e (In vrs. la	ast birthday)		nesda 1 Year		24 Hrs.	8. Date of Bi	rth	ontgo		lace (State	or Foreign
Funeral Director		515-46-8		1□M 2页	_	59	Yrs.	Months	Days	Hours	Min.	(Month, Da 1/14/1	ay, Year)	Coun	try)	or r dreight
		Usual Residence of										1/14/1	1740				
arylar show	=	10a. State	10b. County				Town or Lo	cation							1	0d. Inside (City Limits s 2 ☐ No
the M 28a-f otiffe	ecto	Maryland 10e. Street and Nu	Montgom	ery		Beth	esaa	10f. Zip	Carlo			· · · · · · · · · · · · · · · · · · ·	100 0	itimam of IA/h	at Cour		
th with 23a or 1st be n	al Dir	5236 Wes		У					816				Uni	itizen of Wh	tate	s of	rica
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Directo	11. Marital Status 1 □ Never Mar 3 □ Widowed	ried 2∐ Married 4⊠ Divorced	Arm 1 ☐ If Ye	Decedent Bed Forces? Yes 2X1 es, Give r or Dates:		l l	Vas Dece f Yes, spe □ Yes	cify Cuba	spanic Or n, Mexica Specify:	n, Puerto R	ify Yes or No lican, etc.)	D-	14. Race - Black, Specify:	White,	etc.	
72 hc	Completed	(Spe	15. Decedent's ecify only highest of	Education grade comple	eted)		16a. Deced (Give	lent's Usu kind of wo	al Occupa rk done d	ation Juring mos	st of workin	g	16b. l	Kind of Busi	ness/Ind	dustry	
within ene. than he Me	E G	Elementary/Sec	ondary (0-12)	Colle	ege (1-4or 5	+)	Homem		se retirea,)			Own	n Home	2		
filed Hygi other ent, ti	ပို	17. Father's Name		st)			TOMOM	ano I		18. Mothe	er's Name	(First, Middle					
Ald be Alental rked ric ev	To Be	Ray Kirk	land						1	Nanc	y Stu	debake	er				
should have and have and have and have and have and have and have an and have an an an an an an an an an an an an an		19a. Informant's N	lame/Relationship	(Type. Prin	t)	_	19b. Mailin	g Address	(Street a	and Numb	er or Rural	Route Numi	ber, City	or Town, Si	tate, Zip	Code)	
and and and and and and and and and and		Christop		an / 9	Son					NW W		gton,					
ges 1 t of H or oth		20a. Method of Dis 1 ☐ Burial 2	sposition Cremation 3	□Removal	from State	Ce	ace of Dispo metery, cren	natorý or d	other place		Da			ocation - C	•	·	
tmen tant:			5 ☐ Other (Spe			Nat	ional			- :	1/10/2			s Chu		•	
Depar Impor any ir		21. Signature of F	uneral Service Lig	ensee R	MAR		1					ph Gav NW Was					
		23a. Part1. Enter shock, or he	the dise r e, or co	mplications	thay caused	the death	. Do not ente	er the mod	le of dying	g, such as	cardiac or	respiratory a	arrest,			Approxima Interval Be	etween
Physician		Immediate Cause disease or condition	(Final				1 Lun								6	Onset and Mont	Death
/Medical Examiner		resulting in death)	- (Di	ue to (or as	a consequ	ence of):										
	ē	Sequentially list co	onditions, mmediate	b. — Dı	ue to (or as	a consequ	ence of):										
cuted d ansit	Examiner	Cause (Disease of that initiated event	enying r injury	c.													
cate be executed physician and the burial-transit	EX	resulting in death)	Last		ue to (or as	a consequ	ence of):										
ate be hysici	dical			d													
sertific ding p	Mec	IF FEMALE:		220 If yo	a autoome	nf prognor	201										
The law requires that the death certific the law requires that the death certific ate has been signed by the attending page 2 should be detached for use as:	Physician/Me	23b. Was deceded in the past 12 1 Yes 22 9 Unknown	2 months?	1 🗆 4 🗆	es, outcome Live birth Pregnant at Unknown	2 Fetal	death 3]Ectopic p]Other <i>(s</i> p						23d. Date Mont		ery Day	Year
s that med b	by Pi	Part II. Other sign	ificant condition:	s contributing	g to death bu	at not resul	Iting in the ur	nderlying o	ause give	en in Part I	l.	23e. Did	tobacco	use contrib	ute to th	ne cause of	death?
w requires to been signer should be												1 🔀	Yes 2	2 □ No 3	□ Prob	ably 4]Unknown
	Completed											24a. Was auto perf 1∐ Yes		pri de	ere auto or to co ath?]Yes	psy finding npletion of 2 No	s available cause of
Physiclan: Th r this certificate ral director, pag	Be (25. Was case refe examiner?	rred to medical	Hospital					T Out to			(Check only					
gi isi	은	1 Yes 2X		Hospital:	1 Inpatie		R/Outpatien			4 LJ IVI		e 5 Res				y)	
Te fe	ion	1 🔀 Natural							28c. Injury Work 1 □ \	γαι ∢? Yes 2□		ou. Describe	e how injury occurred				
Attending r death. ector: After by the funer	fical	2 Accident 3 Suicide	6 ☐ Could not determine	be 28e.	Place of inju	ıry - At hor	ne, farm, stre					3f. Location			or Rura	l Route Nu	mber,
s after al Dire	Certification:	4 Homicide	201011111	.	building, etc	э. (Ѕрвсіту,)					City or To	wn, Sta	te)			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man 2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.								ner as s	tated. the cause	(s)					
Virthi Com	Σ	29b. Signature and	title of certier	utt		-			D003					ate signed (uary 7			
10		30. Name and add							#130	O Ch	evv C	hase	MD '	20815			
St	ate	31. Date filed (Mor	nth, Day, Year)		32 Anietra	ar's Signat	Ure			.5 011	cvy U						
Regist	trar		8 O NAL	2008	Res	w d	4										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day $a^{\,M}$ 9"20 January 5, 2008 Margaret Ellen McLaughlin
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death I aure I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Prince George's

9. Birthplace (State or Foreign Country) Laurel Regional Hospital
5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months 1 ☐ M 2 🕱 F April 26, 1921 577-20-8492 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15101 Interlachen Drive, Apt. 214 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Sheaffer Margaret C. Ryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Marie Battiste/Daughter 8708 34th Avenue, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 ☐ Cremation 3 ☐ Removal from State January 9, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the diseate, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure
Due to (or as a consequence of): Chronic Destructive Pulmonary Discard Due to (or as a consequence of): Congestive Heart Failure Due to (or as a consequence of) . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 9□ Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 😾 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical 26. Place of Dea

Physician /Medical Examiner

> the as for use

detached

page certificate

filled in by the funeral

after death Director:

thin 24 hours a

within 7

ပ

signed by

Physician

/Medical

10a. State

Examiner

Funeral

Director

28a-f show notified at

ral", or items 23a or Examiner must be

filed within 72 hours

Il Hygiene.

and Mental I 2 should be

Fages 1 0

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

traumatic event,

other

injury

2121

and

Mary

Baltimore,

JZ

Director

Funeral

Completed by

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-trar and resulting in death) Last

Physician/Medical

2

Completed

Be

Certification: To

Medical

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

and manner stated.

-Diabetes

ath (Cl	neck only one)	
lome	5 Residence	6 □Other (Specify

Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing F 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation

29c. License number

М 1 ☐ Yes 2 ☐ No 28e. Place of injury - At hom building, etc. (Specify) At home, farm, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6 ☐ Could not be determined

DOO 645 39

29d. Date signed (Month, Day, Year)

K-Shi allie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Srilatha Kanumuru, MD 7300 Van Dusen Road, Laurel, MD 20707

31. Date filed (Month, Day, Year) State

examiner?

27. Manner of Death

Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

1 ☐ Yes 2 ☐ No

JAN () 8 2008



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** Year 2008 0358 Seward Maxwell Mende Jan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KehabaNursingCtr isburc Wicomico If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, May 23, Social Security Number 7. Age (In yrs Jast birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 □ F Maryland 212-14-4262 90 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dorchester Cambridge MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21613 USA 5529 Whitehall Road Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 No à Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) chemical 11 <u>plant supervisor</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarissa R. Seward Eric Mende ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is 1 any injury or other 5299 Chinaberry Dr., Salisbury, MD Kathleen Mende wife 21801 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Salisbury, MD 1/8/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** las disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 9 lag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed attending physician and I for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the s 1 Ves 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? I□ Yes 2 1 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, for

State Registrar

Medical

29a. Certifier

(Check only

29h. Signature and title of certifie

lilliam

31. Date filed (Month, Day, Year) JAN 0 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d, Date signed (Month, Day, Year)

01396

Physician
/Medica
Examine
Funeral

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, SR. MICHAEL SCOTT MAYO, MICHAEL SCOTT MAYO, SR. MI		1 - State Registrar		Certifica	ate of Dea	ath	Reg	1. No. 200	8 0139	
CHESTER IVEN HOSPITAL CENTER CRESTRIVEN NOTES IN THE PROPERTY OF DESTRICT OF CHESTORY ON THE PROPERTY OF THE	_						Month	Day Year	3. Time of Death	
CHESTER RIVER HOSPITAL CENTER C. Sex	cal .			Als Cit	. Town orload	tion of Dooth	JANUAKY			
213-94-0460 18 20 100. Clumps 100.	ner									
1980 1980							8. Date of Birth	9. Bi		
State 100. Control 100. Colty, Town or Location 100. Inside and Part Details 100. Colty or Town or Location 100. Street and Part Details 100. Colty or Town or Location 100. Colty or Town or Location 100. Colty or Town or Location 100. Colty or Town or Location 100. Colty or Town or Location 100. Colty or Town or Location 100. Colty or Location		213 -94-0440 ¹¾™	2□ F	Month	s Days Ho	ours Min.	(Month, Day,)	rear) l c	Country)	
23a Part - New fundisons and shrees or personal faultier. List only disease, or confiderations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleath faultier. List only be cause on each line. Approximate shock, or fleath faultier. List only be cause on each line. Immediate Cause Final resulting in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Beautifing in death. Approximate consistent and beath ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death.	1		10c. City,	Town or Location					10d. Inside City Lim	
1.24 MIRPHY ROAD 1.1. Marins Blass 1.2 Was Dependent Ever in U.S. 1.3 Was Depodent of Hispanic Cityset (Specify yes or No. 1) 1.4 Race. American Indian. 1.5 Race 1.5 Receive 1.5 Rece	ector		E'S CE				1.0	C	1 □ Yes 2 🕱	
Specific Numbers Specific Nu				10f. 2						
23a Part - New fundisons and shrees or personal faultier. List only disease, or confiderations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleath faultier. List only be cause on each line. Approximate shock, or fleath faultier. List only be cause on each line. Immediate Cause Final resulting in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Beautifing in death. Approximate consistent and beath ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death.		11. Waltar States	Armed Forces?				ecify Yes or No- Rican, etc.)	Black, Wh	ite, etc.	
23a Part - New fundisons and shrees or personal faultier. List only disease, or confiderations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleath faultier. List only be cause on each line. Approximate shock, or fleath faultier. List only be cause on each line. Immediate Cause Final resulting in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Beautifing in death. Approximate consistent and beath ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death.		3 ☐ Widowed 4 ☐ Divorced	rear or Dates: 1982-	1986						
23a Pint-Mark to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only because on each line. Immediate Cause (Final resulting in death) Approximate shock, or freat failure. List only because on each line. METASTATIC MELANUMA Approximate Cheek and Death Consideration of the Consider	plete	(Specify only highest grade con	mpleted)	16a. Decedent's U: (Give kind of u life. DO NOT	sual Occupation work done during use retired)	g most of worki	ing 10	6b. Kind of Busines	s/Industry	
23a Pint-Mark to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only because on each line. Immediate Cause (Final resulting in death) Approximate shock, or freat failure. List only because on each line. METASTATIC MELANUMA Approximate Cheek and Death Consideration of the Consider	E			PROJECT	MANAGE	R	N	EW HOME	CONSTRUCTIO	
23a Pint-Mark to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only because on each line. Immediate Cause (Final resulting in death) Approximate shock, or freat failure. List only because on each line. METASTATIC MELANUMA Approximate Cheek and Death Consideration of the Consider		17. Father's Name (First, Middle, Last)			18. 1	Mother's Name	(First, Middle, Ma	aiden Surname)		
23a Pint-Mark to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only because on each line. Immediate Cause (Final resulting in death) Approximate shock, or freat failure. List only because on each line. METASTATIC MELANUMA Approximate Cheek and Death Consideration of the Consider		MICHAEL RAND MAYO			:	BONNIE	LEE ECKE	RT		
23a Part - New fundisons and shrees or personal faultier. List only disease, or confiderations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleath faultier. List only be cause on each line. Approximate shock, or fleath faultier. List only be cause on each line. Immediate Cause Final resulting in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Beautifing in death. Approximate consistent and beath ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death.		19a. Informant's Name/Relationship (Type. I	Print)						Zip Code)	
23a Pint-Mark to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only because on each line. Immediate Cause (Final resulting in death) Approximate shock, or freat failure. List only because on each line. METASTATIC MELANUMA Approximate Cheek and Death Consideration of the Consider									r Town State	
23a Part - New fundisons and shrees or personal faultier. List only disease, or confiderations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleath faultier. List only be cause on each line. Approximate shock, or fleath faultier. List only be cause on each line. Immediate Cause Final resulting in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Approximate consistent and beath ceutifing in death. Beautifing in death. Approximate consistent and beath ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death. Approximate ceutifing in death.		1 ☐ Burial 2 【Cremation 3 ☐ Remo	oval from State CHES	metery, crematory of SAPEAKE CR	r other place)					
Approximate referred to medical suspense of confidence of the past 12 months? Approximate resulting in death Deate (or as a consequence of):		21. Signature of Funeral Service Licensee	OLD							
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		23a. Parti. Enter the disease, or complications shock or heart failure. List only one complications	ons that caused the death						Approximate Interval Between	
Due to (or as a consequence of): Due to (or as a consequence of):		Immediate Cause (Final								
The contribution of the					··· CLATO	D7777			4 MENTING	
Text initiated events Text		b								
Text initiated events Text	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):						
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Use b Use 1 Use 2	Ē	that initiated events								
23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown 1 yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 1 Yes 2 No 9 Unknown 23d. Date of delivery Nonth Day Year 1 Yes 2 No 9 Unknown 2 No 9 Un		resulting in death) Last	Due to (or as a consequ	ence of):						
23b. Was decedent pregnant in the past 12 months? 1	dica	• d						· · ·		
1 Yes 2 No 3 Probably 4 Unknot		23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic						
1 Yes 2 No 3 Probably 4 Unknoted	ار ک	9 LI UNKNOWN								
25. Was case referred to medical examiner?	þ	Part II. Other significant conditions contrib	uting to death but not resu	Iting in the underlying	g cause given in	Part I.				
25. Was case referred to medical examiner?	plete							24b. Were	autopsy findings availa	
25. Was case referred to medical examiner?	E						perform	ed? death	?	
The particle The		25. Was case referred to medical			26.	Place of Death			20 20110	
27. Manner of Death Natural 2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office 29e. Certifier (Check only one) 29e. Signature and fittly of certifier 29e. Signature and fittly of certifier 30e. Mame and address of person who completed cause of death (Item 23a) (Type, Print) 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office 28e. Place of injury - At home, farm, street, factory, office 28e. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Clack only of Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28e. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Clack only of Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28e. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Clack only of Could not be determined 28e. Clack only of Could not be determined 28e. Clack only of Could not be determined 28e. Clack only of Could not only of Could not only of Could not only of Could not only of Could not only of Could not only of C	0	examiner?	ital: 1 ☐ Inpatient 2 🔽 E	ER/Outpatient 3□	Other				pec/fv)	
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and fittle of certifier 29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN J. D'Keefe M.D.: 2003 Medicat Parkway Sick IVV ANNApolis Mg 2003	 	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?							
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and fittle of certifier 29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN J. D'Keefe M.D.: 2003 Medicat Parkway Sick IVV ANNApolis Mg 2003	ertifica	3 Suicide 6 Could not be	8e. Place of injury - At hor building, etc. (Specify	me, farm, street, fact)					Rural Route Number,	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN J. O'Keefe M.D. 2003 Medicar Parkway Suck 100 Annapolis MO 20		(Check only 2 Medical Examiner:	On the basis of examinat							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN J. D'Keefe M.D. 2003 Medicar Parkway Suck 100 Annapolis MO 20	Mec		and manner stated.		29c. License nur	nber	29	d. Date signed (Mo	nth, Day, Year)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KEVIN J. D'Keefe M.D. 2003 Medicar Parkway Suck 100 Annapolis Mg 20		14 Oller	AD.	•	D 352	59				
KEVIN J. D'Keefe M.D. 2003 Medicar PARKWAY Suck 100 ANNApolis MA 21 ate 31. Date filed (Month, Day, Year) 32 Registrar's Signature		30. Name and address of person who compl	eted cause of death (Item	23a) (Type, Print)				MAN WATER	., 2003	
ate 31. Date filed (Month, Day, Year) 32. Registrar's Signature		(), (4	D: 2003	Medica	42 PAZE	cuta Sin	KIUD AND	vacilis un De	
	ate			ure			1	- 100 1100	y any an	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 1. Decedent's Name (First, Middle, Lest) 3. Time of Death **Physician** January 01, 2008 I1se L. Maves 2:00pm /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Name (If not institution, give street end number) Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Deys 1 □ M 2 🛛 F 90 Yrs. 579-50-1009 Dec. 15, 1917 Germany Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 √ Yes 2 □ No Director DC Washington 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 4201 Butterworth Place NW #447 20016 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Library Assistant University 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown Hansen ပ္ 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Patricia Mayes / Daughter 1760 Pacific Avenue #9, San Francisco, CA 94109 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removel from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1/5/08 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Pert1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, at leart fature. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) e_Congestive Heart Failure Due to (or es a consequence of) Examiner Hypertensive Heart Disease Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events Due to (or es e consequence of) Cerebrovascular Accident edicai Due to (or as e consequence of) resulting in death) Last Pulmonary Hypertension Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 □ Yes 252 No. 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2⊠ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier D47330 DSUNI 1/03/2008 womes 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Thomas V. Joseph 50 West Edmonston Drive #207, Rockville, MD 20852

Registrar

State

31. Date filed (Month, Day, Year)

JAN 07 2008

'Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at

filed within 72 hours aftar

permit. Peges 1 and 2 should be f Depertment of Health and Mentel I

ie marked of

If item 27 is

Physician

/Medical

Examiner

attending p

director

this After this funeral of

n 24 hours after deeth.

Ne Funeral Director: Alphabely filled in by the fu

To the Hosp within 24 ho To the Fune completely fi

6

Attending Physician: The law requires that the death certificeta be executed

Division of Vital Records, P.O. Box 68760

3altimore, Maryland 21215-0020

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 8 per fh e875 1-25-08 vt. State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Helen L. Miller Jan. 6:44 A M 11, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1929 | Months | Days | Hours | Min. | Oct. 26, 19 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🔀 F 215-28-8434 78 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a, State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 14 Yes 2 □ No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Bridge Lake Circle 21030 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify <u>≥</u> Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker d 2 should be filed w th and Mental Hygier 7 is marked other th 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any Injury or other traumatic ev Shadrach C. Cole Nannie R. Lloyd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Sturgill 8 Bridge Lake Circle, Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory of other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan.15, 2008 Timonium, MD 21. Signatury of Fundral Service 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 PMA Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition med as fatic Physician DUNIM CANCER months disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. pe Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) P.O. I signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy page certificate 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA 은 this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Certification: Division To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

January 11, 2008 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) M. Charles St. Bolto. Nd 21208 6701 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Bernard Mossburg January 11 2008 6:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Months Days 1 X M 2 □ F 86 220-16-1926 February 12, 1921 Director Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits Frederick Frederick Maryland 1 ∏Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r with 7417 Ridge Road 21702 United States Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after a ealth and Mental Hygiene. n 27 is marked other than "natural", or ite 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 👿 No 1 Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Cement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Cleveland Mossburg Francis Oland ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If item 27 is
any injury or other trau 7417 Ridge Road, Frederick, Maryland 21702 Blanche V. Mossburg / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Januar Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 15, 2008 Frederick, Maryland Z2. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
106 Fast Church St., Frederick, MD 21. Signature of Funeral Service Licenses MOIZZZ Jaequelle Rus 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Seusis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Calspass or injury Due to (or as a consequence of) Examiner Cause (Discuss or inju that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the ası IF FEMALE nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 cate has been signated bage 2 should b 1 ☐ Yes 2☑No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes certificate 2 No 2 1No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3□ DOA r this 28a. Date of Injury (Month, Day Year) Hospital or Attending Pl
 4 hours after death.
 Funeral Director: After th 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🔽 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Registrar

31. Date filed (Month, Day, Year)

Lamont C. Smith M.D.

(Check only

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 West Seventh Street, Frederick, Maryland 21701

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

00052950

29d. Date signed (Month, Day, Year)

14, 2008

08-00371 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Raymond Thomas Norton 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 13, 2008 Year 1225 hrs Medical Examiner RAYMOND NORTON 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Center Prince George's Clinton 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 6. Sex Country) Days Hours Months Director 1 XM 2 19, 1959 NEW YORK 577-86-6669 48 Usual Residence of Decedent 10a. State 10d, Inside City Limits 10b. County 10c. City, Town or Location Yes 2 No items 23a or 28a-f show ast be notified at once. PRINCE GEORGES TEMPLE HILLS MD. Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 20748 U.S.A 4612 SHARON RD. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X Married 1 Never Married Yes If Yes, Give Year Specify: WHITE 1 Yes 2x No specify: 3 Widowed 4 Divorced ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) remit. Pages I and 2 should be filed within 72 lepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "niury or other traumatic event, the Medical. Baltimore, MD 21215-0036 ROSECROFT RACEWAY HORSEMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHIRLEY SHIMINSKI RAYMOND NORTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TEMPLE HILLS, NORTON/WIFE SHARON RD., MD. **JENNY** 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State CHAMBERS CREMATORY 1-15-2008 RIVERDALE, MD. Donation 5 Other Specify: 22. Name and Address of Facility
CHAMBERS FUNERAL HOME
M00091 5801 CLEVELAND AVE., 21. Signature of Funeral Service Licenses E & CREMATORIUM, P.A. RIVERDALE, MD. 20737 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed nin 24 hours after death. and tran Physician/Medical AMENDED #23a,PTI,27,perME,g875 X UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 ✔ Unknown <u>Bilateral</u> pneumonia Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 1 ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other₄ examiner? Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence After this ဥ 1 V Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural Yes 2 Pending within 24 hours after death To the Funeral Director: 2 Accident Investigation in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 14, 2008 O.C.M.E. loni 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. egistrar's Signatute State 2008 16 Miller.

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

OCME

ORIGINAL

			Pleas . For					. Ensure A lealth and N	•	ene	
			1 - State Registrar			Ce	rtificate of	Death	T	g. No. 2 1 1 2	011.01
	Physicia /Medic		1. Decedent's Name (First, Middle, Nannie		eal				2. Date of Death Month January		3: Timb of Death 1 1:15 PM M
	Examin		4a. Facility Name (If not institution, 10233 No1an	_	umber)		4b. City, Town, o	r Location of Death		4c. County of Death	
¥200	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birth	nplace (State or Foreign
%.	Director		215-20-4195 Usual Residence of Decedent	1 □ M 2 🗓 F	103	Yrs.	Months Days	Hours Min.	Jan 4,	Year) Co.	ginia
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show iteal Examiner must be notified at	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	be filed within 72 hours after death with the Marylan Hygiene. 4 other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	Maryland Mont	gomery		Mount	Airy 10f. Zip Code		110	g. Citizen of What Co	1 ☐ Yes 2 No
	3a or		28607 Kempto	own Road			2177	7 1		U.S.A.	unu y ?
	death	Funeral	11. Marital Status	12 Was De	cedent Ever in U	J.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Amer Black, White	
ဥ	s after ; or Ite	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 K) Widowed 4 ☐ Divorced	ed 1 Yes If Yes, G	Forces? 2 X Vo		1 □ Yes 2 □XNo	Specify:	Triodit, etc.)	Specific	
5-0036	2 hour		15. Decedent'	Year or I		16a. Dece	dent's Usual Occup	oation	11	6b. Kind of Business/I	hite ndustry
212	within 72 lene. than "na he Medi	Completed	(Specify only highest Elementary/Secondary (0-12)	1	(1-4or 5+)	1	_	during most of worl d)	king		
7	filed wi Hygien ther th	S	9 17. Father's Name (<i>First, Middle, L</i>	l act)		Но	memaker	19 Mothode Nom	e (First, Middle, M	Own Home	
	ild be fi lental F ked ot Ic ever	o Be	Samuel Harmo						. , ,	sclose	
ar Z	shound Mind Mind Mind Mind Mind Mind Mind Mi	으	19a. Informant's Name/Relationsh			19b. Maili	ng Address (Street			City or Town, State, Z	(ip Code)
2	1 and 2 Health a em 27 is other trai		Self by prearr	angement		2860	7 Kemptov	vn Road,	Mount Ai	iry, Maryla	and 21771
lore	ages 1 a int of Hea int of Hea int item / or othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation		n State	cemetery, cre	osition (Name of matory or other pla	ce)		20c. Location - City or	,
	permit. Page Department (Important: If any Injury or once.		4 □ Donation 5 □ Other (Sp 21. Signature of Puneral Service L		H			tery Jan		Gaithersb	_
Dalt	Department of the control of the con		1 trut L	C. Wil	llian	7 2	6401 Rid	ge Road,	Damascu	Funeral Hors, Marylan	d 20872
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complications that only one cause on a.	caused the dea each line.	th. Do not en	ter the mode of dyi	ng, such s cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to	o (or as	quence of): ,	_	11			Vigars
Si		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	logas a consec	quança ol).		11		_	Jews,
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	(or as a consec	ve ,	reva	- for	Lure		years
	s be ey	alE		C	21000e	ery.	arte	Les de	u oas	e	Hears
00	tificate ig phy as the	ledic		0.							
X D D	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregn birth 2 ☐ Fet	al death 3	⊒Ectopic pregnanc	у		23d. Date of deli	very Dav Year
	the de y the a sched f	ysic	1 ☐ Yes 2 [X]No 9 ☐ Unknown	4∐Preg 9□Unk	gnant at time of a	death 5L	Other (specify) _				
λ F	law requires that the as been signed by th 2 should be detache	by Pi	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords	requir een si								1 ☐ Ye	s 🛣 No 3 □ Pro	obably 4 □Unknown
	The law ate has b	Completed							24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of 2 No
	stan:	Be C	25. Was case referred to medical examiner?					26. Place of Dear	1 Yes 2 th (Check only one	No 1 □ Yes	Daughters
5	Physic this o	2	1 ☐ Yes 2 ☒ No 27. Manner of Death		Inpatient 2	ER/Outpatier		4 □ Nursing H		nce 6X Other (Spec	eify) Home
200	ding h. : After funer	tion	1 Natural 5 Pending 2 Accident investiga	(Mo	onth, Day Year)	Injury	Wor	rk? Yes 2∐No	28d. Describe hor	w injury occurred	
<u> </u>	Atter er deal rector by the	Certification:	3 ☐ Suicide 6 ☐ Could not determine	ned 286, Plac	ce of injury - At h		eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ıral Route Number,
2	Iltal or Ins afte ral Dil										
	To the Hospital or Attending Physician: The law within 24 burns after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Examiner: On the	ne best of my kni basis of examin inner stated.	owledge, deat ation and/or in	n occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
	To the To the Complet	Me	29b. Signature and little of certifier	2811	V.	/	29c. Licens	se number	29	d. Date signed (Monti	n, Day, Year)
			Mente	s W.	rare	sh	7 7	01/4	D	January 7,	2008
7	\		30. Name and address of person we Charles W. Ka	resh M.D	. 2600:	3 Ridge	Road, D	amascus,	Maryland	20872	
	Sta Registr		31. Date filed (Month, Day, Year)	2008	Registrar's Sign	ature do	ule				
			JAP U O	2000	SHIP -				· · · · · · · · · · · · · · · · · · ·		

State Registrar Mc Cutch EON

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

E. CARROLL

100

32. Registrar's Signature

MD

2008

3-00327			pe or Print i									gible	Э.		
seph P. O'Cor	P. O'Connor State of Maryland / Department of Health and Mental Hygiene 1- For State														
		Registrar		Cer	tificate c	of D	eath					Reg. No.	6	101	
Physicia		Decedent's Name (First, Midd	•								Date of Dea Month	Day	Ye	ear	3. Time of Death 0910 hrs
edical Exami		Joseph Patrick 4a. Facility Name (if not institution				1h	City, Town	or Lo	eation of I		January 1			of Deatl	
r .		603 B Admiral Drive A		amber)			Annapoli:		cation of t	Dealli				Arundel	1
Funeral		Social Security Number	6. Sex	7. Age (In yrs. la	ist birthday)		f Under 1		If Under 2	24Hrs.	8. Date of B	irth (MM	/DD/YYY		rthplace (State or
Director		216-68-8701	1X M 2 F		51 Y	rs.	Months [Days	Hours	Min.	5/30	/195	56	Forei	gn ountry) DC
	ŀ	Usual Residence of Decedent						_		L—I		•			
any	Ì	10a. State 10b. County			Town or Loca										10d. Inside City Limits
VV Aaryland 28a-f show d at once.	٦	MD Anne	Arunde1	Ann	apolis										1 Yes 2 X No
28a-f	ect	10e. Street and Number				10	Of. Zip Cod					-		Vhat Cou	intry?
with the Mar ms 23a or 28s be notified a	Funeral Director	603 B Admiral I	DR.				21	401	L			US	5A		
the m	era	11. Marital Status 1 Never Married 2 M	12. Was De Armed F	cedent Ever in U.Sorces?	S. 13. W	Vas D Yes,	ecedent of specify Cu	Hispa ban, N	anic Origin Mexican, F	? (Spec Puerto Ri	ify Yes or N can, etc.)	0-		ce - Amei ite, etc.	rican Indian, Black,
or deal	교		1 Yes	2XX No									Specify		White
rs afte ural", mine	by	3 Widowed 4 X Div 15. Decedent's Education (Spe	vorced If Yes, Give Ye or Dates:		16a. Decede		es 2 X			nd of wor	k done	16b.			/Industry
2 hou "nat	Completed	Elementary/Secondary (0-12)		1-4 or 5+)			of working								
D36 thin 7 re.	nple		2		Sa	1e	s					I	Beer		
5-0036 led within 72 tygiene. other than	S	17. Father's Name (First, Middle	, Last)							,	irst, Middle,		Surnan	ne)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	John Thomas 0'0		•							Cleme	_			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relations Lynn Russell	ship (Type, Print) Sister		19b. Maili	ing Ad Be	ddress (S $11\ {\sf St}$	treet a	and Numb Hend	er or Ru .ersc	n, MD	mber, 0 21 <i>6</i>	City or To	own, Stat	e, Zip Code)
MD and 2 sho salth and em 27 is raumati		20a. Method of Disposition		20h F	Place of Disp						Date			n - City o	r Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If itel		1 XX Burial 2 Cremation	n 3 Removal f	rom State	rematory or thern	other	place)			1/16	/2008	1		rk,	
ti Pag t. Pag tment rtant: y or ot		4 Donation 5 Other S		Bou											e, P.A.
Balt permit Depart Impor injury		21. Signature of Funeral Service	Licensee								iesty iapoli				e, 1.A.
Physician		23a. Part I. Enter the disease, or	r complications that	caused the death.											Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease		llin resis	tant sta	aphy	v1ococ	cus	aureu	s sen	sis				Between Onset and Death
aminer		or condition resulting in death)		a consequence of			,								
		Sequentially list conditions,	b	a consectance of	n.										
	jine	ff any, leading to framedate cause. Enter Underlying Cause		а сопънсимпон от	T):										
ti ti	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									-				
executed an and al - transit	ca E		d												
ੂਲ ਲੋ ਦੇ	odic	X UNPENDED	AMENDED #23a	27.perME.g8	876 <u>.</u> 2/	1/08	3 TT _								
376 ficate g phy s the t	an/Medi	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregi		Fetal	death	3	Ectopic p	pregnano	CV	23	3d. Date Month	of delive	ny Day Year
Box 68760, e death certificate be the attending physic of for use as the bur	sicia	past 12 months?	4 Preg	nant at time of de	oth _		(Specify)	-							•
Bo; e deatl the att	Phys		lknown g Unkr												
P.O. s that the gned by e detach	by P	Part II. Other significant condi	tions contributing	to death but not re	esulting in the	e und	erlying cau	ise giv	en in Part	: I.	processors	_	_		o the cause of death?
S, P.C uires that n signed l						-					24a. Wa				autopsy findings available
cords, law requir has been s	Completed										auto	opsy formed?			completion of cause of
Rec The la	E											2		1 🗸	
tal Rectian: The certificate ector, page	Be	25. Was case referred to medica examiner?		12-2	-		26.F		of Death (C	Check or	ly one)				
of Vital Records, ng Physician: The law require Niter this certificate has been si meral director, page 2 should t	5	1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie						Home 5				er: Scene
n of ding Pl After funera	ü	27. Manner of Death 1 X Natural 5 Pen		e of Injury th, Day,Year)	28b. Time o	of Inju	´ I .		at Work?	- 1	8d. Describ	e now in	ijury occ	urrea	
ivisior or Attendafter death Director:	cati	- reli	estigation	ce of Injury - At ho	ame form at	-00t 1					of Location	(Street	and Nur	mber or F	Rural Route Number, City
Division at or Attendir rs after death. at Director: A	Certification:	dete	old not be Specify		ome, iaim, si	1001,	ractory, om	CC DU	ilanig, ctc.		or Town,		ana 14a		tarar reacto rearrison, oxy
E 8 E		29a. Certifier	Physician: To the be		ge, death occ	currer	at the tim	e, date	e and plac	e, and d	ue to the ca	use(s) a	ind man	ner as sta	ated.
To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Exa	aminer:On the basis	of examination a	nd/or investig	gation	n, in my opi	nion,	death occi	urred at	the time, dat	e and p	lace, an	d due to	the cause(s)
To To	Me	29b. Signature and title of certifi	and manner er	stated.			29c. Lic	cense	number			29d	. Date si	gned (M	lonth, Day, Year)
	- 1	(mets_	`				0	.C.M	I.E.			Jai	nuary	13, 200	80
		30. Name and address of person	n who completed cau	use of death (Item	23a)		L								
Į.	1	Ana Rubio MD. As	sistant Medical	Examiner	111 Penn	Stre	eet. Balt	imor	e, MD 2	21201					

State Registrar 31. Date filed (Month, Day, Year) 1 5 2008 32. Restrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14, 2008 anuar WILLIAM HOWARD PICKLE SR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Director 225-30-5251 79 MAY 17,1928 VIRGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sh notified 1 ☐ Yes 2 No Director MD CHARLES WHITE PLAINS 10g. Citizen of What Country? 10e Street and Number 10f Zin Code ms 23a or 7 8395 BILLINGSLEY U.S. ROAD 20695 Α. Funeral items 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Gyes 2 No If Yes, Give Year or Dates: 51 - '53 1 Never Married & Married ō 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the CARPENTER HOME BUILDING marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUTHER PICKLE EDNA MAE REEDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ø VELETTA B. PICKLE/WIFE 8395 BILLINGSLEY RD. WHITE PLAINS, MD 20695 Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State JANŬÄRY ö 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) TRINITY MEM.GRDNS, 18,2008 | WALDORF, MARYLAND 21. Signature of Funeral Service Licen 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician erus rm X one WK /Medical Due to (or as a consequence of): Examiner HTHERWS CLIENUS I Securitally its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 I Inknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res (X)No page 2 1∐ Yes Physician: 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes No. 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident death. hours after death uneral Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Vital Records. 0 24 hours a completely within 2 To the

wil

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifie

30. Name and address of person

SEOTG Date filed (Month, Day, n who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

11345 Pembrooke Sq. Waldor C.MD. 2063

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible
State of Maryland / Department of He	ealth and Mental Hygiene

3 ,	F	- For State Registrar		tificate o	f Death		Reg	20 (08 0140	
Physicia Medical Examir	-	1. Decedent's Name (First, Middle,Last Angela Denise					2. Date of Death Month	Day Year	3. Time of Death 2343 hrs	
VIEUICAI EXAIIII		4a. Facility Name (if not institution, give	•		4b. City, Town, o	r Location of Death	January 3,	4c. County of Deat		
		University Of MD Hospital			Baltimore					
Funeral		5. Social Security Number 6. Se.	3 \ 1	st birthday)	If Under 1 Ye Months Da		_	(MM/DD/YYYY) 9. Bi Forei	rthplace (State or gWashington,	
Director		373-00-4034	M 2XF 40	Yrs		ys 110010 11111	Oct11	1967 C	DC	
any	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	tion		-		10d. Inside City Limits	
* ·	Ļ	Manuel and Dudnes	Campala	Linton					1 X Yes 2 No	
Maryland or 28a-f show	Director	Maryland Prince 10e. Street and Number	George ST C	LINCON	10f. Zip Code		10	g. Citizen of What Cou	intry?	
h with the Maryland h with the Maryland ems 23a or 28a-f she the notified at once		9212 Stuart Lane			20735			United :	States	
72 hours after death with the Maryland n"matural", or items 23a or 28a-f she al Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?			lispanic Ongin? (S an, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,	
er dea			1 Yes 2 X No		Yes 2 X N	o snecify:		Specify: Ame	Frican	
turs aff	ap P	15. Decedent's Education (Specify on	or Dates:	16a. Decede	nt's Usual Occup	ation (Give kind of		16b. Kind of Business		
6 72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during n	nost of working lif	e. DO NOT use ref	tired)			
5-0036 led within Hygiene. other tha	mo l	17. Father's Name (First, Middle, Last)	5 years	Gui	dance Co	ounselor	e (First, Middle, M	Governmen	nt	
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", e event, the Medical Examiner	BeC	Richard Leon Pey	ton. Sr.				e (First, Middle, W es Richar			
21215 ould be file d Mental H s marked o ic event, tl		19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Stre			ber, City or Town, Star	e, Zip Code)	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ex		Frances R. Hairst						111s, MD 20		
of Hear In the International		20a. Method of Disposition 1 X Burial 2 Cremation 3		Place of Dispo crematory or o	sition (Name of c ther place)	emetery,	Date	20c. Location - City of	r Town, State	
Baltimore, permit. Pages I ar Department of Her Important: If ite	1	4 Donation 5 Other Specify:			1 Cemete		10, 200			
Bal permi Depar Impo	1. Signature of Funeral rvice Li e 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 200									
Physician		23 i. Part I. Enter the disse, or compl							Approximate Interval Between Onset and	
/Medical	1	failu e. List only one cause on ea Immediate Cause (Final disease a.	Gunshot wound of	head					Death	
Adminici		or condition resulting in death)	Due to (or as a consequence o	f):						
	ē		Due to (or as a consequence o	f):	_					
	Ę١	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence o	f)·					-	
zuted nd ransit		events resulting in death) Last dd.	300 10 (0) 20 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	·/·						
760, icate be executed physician and the burial - transit	Medical	X UNPENDED	##23a,27,28a-f, p	erE,g877	3/12/08	Π				
Box 68760, e death certificate be the attending physic ed for use as the bur	~ '	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy		Ectopic pregr	nancy	23d. Date of deliver	ry Day Year	
eath certific	iciar	past 12 months?	4 Pregnant at time of de	oth -	etal death 3 ther (Specify)	cotopic progr	iancy	Monat	24,	
Bo he deal	Physician	1 Yes 2 No 9 V Unknown	9 Unknown			ation in Park	- 220 Did to	bacco use contribute t	o the cause of death?	
ires that the signed by	ğ	Part II. Other significant conditions	contributing to death but not in	esalang in the	underlying cause	e given in Fait i.			obably 4 Unknown	
ords, w require	Completed						24a. Was a		autopsy findings available	
e law i	E I						autop: perfor	med? death?		
tal Rec ician: The certificate rector, page		25. Was case referred to medical			26.Pla	ce of Death (Check			763 2 110	
Vita	o Be	examiner? 1 ✓ Yes 2 No	ospital: 1 / Inpatient 2	ER/Outpatier	t 3 DOA	Other Nurs	ing Home 5	Residence 6 Oth	er:	
n of V Jing Phy After tl funeral	֓֞֝֟֝ <u>֚֚֚֚֚֚֚֚</u>	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year)	28b. Time of	· · _	jury at Work?	28d. Describe h	now injury occurred		
ivisior or Attend after death Director:	lăi	2 Accident 5 Pending Investigation	FNd 1/2/2008 28e. Place of Injury - At he	Fnd 9:3	o am	Yes 2 X No	unk	Street and Number or I	Rural Route Number, City	
Division of Vital Records, rater death. To after death. In Director: After this certificate has been is led in by the funeral director, page 2 should be a by the funeral director, page 2 should be a by the funeral director.	Certification:	3 Suicide 6 X Could not I determined	oe i	und at r	•	e ballariig, etc.	or Town, S	tate) art Lane Cli	-	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Phystrian: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil		29a. Certifier 1 Certifying Physici	an: To the best of my knowled	ge, death occu	irred at the time,		d due to the caus	e(s) and manner as st	ated.	
To the within To the comple	Medical	one) 2 Medical Examiner	On the basis of examination a and manner stated.	nd/or investiga			at the time, date			
LOPA	Σ	29b. Signature and title of certifier	\cap			nse number		29d. Date signed (A January 4, 200	•	
Y W		(where	olly)	220)	0.0	C.M.E.		January 4, 200	<u> </u>	
4		 Time and address of person who can Laron Locke MD. Assist 	omplied cause of death (Item ant Medical Examiner		n Street, Ball	timore, MD 21	201			
Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signatu		2.0					
Regist	ar	JAN 1 4 2008	Kleine B.	4004						

DHMH 17 Rev 1/2001 OCME 2006

1-04 pard-vaying 1200inson

OCME

ORIGINAL

Division or Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

JAN

7+1 VA

20850

David A. Charles, MD, 15005 Shady Grove Rd., Suite 410, Rockville, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend #8 PEr INF G876 2/07/08 edificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2003 Month **Physician** pleste January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOPKINS Hospita Date of Birth 11-13-19 Arthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** Months Days Hours 1 □ M 2 💢 F Philippines 219-65-8885 30 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 🙀 No iral", or items 23a or 28a-f sh Examiner must be notified Director MD Montgomery Montgomery Village 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 18315 Lost Knife Circle #102 United States 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1X Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: Filipino þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul T. Pruna Cecilia L. Lorenzo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 Cecilia L. Pruna (Mother) 18315 Lost Knife Circle #102 Montgomery Village,MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 1 hours Immediate Cause (Final disease or condition resulting in death) Physician Sepsis

Due F (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of); Examine be executed burial-transit +mm4n0supression Due to (or as a consequence of) attending physician B. lineage Physician/Medical the as IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? for Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 s performed? Yes 2 No certificate 2 No 1 TYes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို After this funeral din Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury within 24 hours arter con-1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Andrew Kay Johns 31. Date filed (Month, Day, Year)

JAN 07 2008

Res-000

Hopkins Hospital, 600 North Wolfe Street, Baltimere

Kan Medical Doctor

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

		For State Registrar	State of I	Maryland		artment rtificate			nd Me		giene. Reg. No.	2008	01408
Physicia		Decedent's Name (First, Middle, L Leah Barbar	,						- 1	2. Date of Dea Month January	ath Day 01	Year 2008	
/Medica Examine	_	4a. Facility Name (If not institution, gi		er)		4b. City,	Fown, or	Location of		Januar y		County of Dea	
Funeral Director				al Age (In yrs. las 81	t birthday) Yrs.	If Under Months		aure1 If Under 2 Hours	Min.	8. Date of Birt (Month, Day March 2	y, Year)	9. Bir	George's thplace (State or Foreign ountry) 11inois
Maryland a-f show ifled at	tor	Usual Residence of Decedent 10a. State 10b. County	gomery	10c. City, 1	Fown or Lo	cation	Si1	ver Sp:	ring				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the	l Direc	10e. Street and Number	Dood #211			10f. Zip	Code	20904			10g. Citiz	zen of What C	•
al"; o	by Funeral Director	3126 Gracefield 11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 if Yes, Give Year or Date	s? ∑No		Was Deced If Yes, spec			in? (Spec Puerto R	cify Yes or No- lican, etc.)		14. Race - Ame Black, Whi Specify:	erican Indian,
ed within 72 hours afi giene. er than "natural", or , the Medical Exa <u>ml</u>	Completed	15. Decedent's E (Specify only highest gi	Education rade completed) College (1-4d 4		(Give	dent's Usua kind of wor DO NOT us	k done d	uring most)	of working	g	16b. Kir	od of Business Own He	·
ind year of the vithin the and Mental Hygiene. It is marked other than "traumatic event, the Mex	To Be C	17. Father's Name (First, Middle, Las		•				18. Mother		(First, Middle,		Surname)	
12 sho h and h 7 Is ma trauma		19a. Informant's Name/Relationship								Route Numbe			• •
permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tre		Edwin Ivan Pilchard 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 4 □ Donation 5 □ Other (Spec	☐Removal from Sta	te cerr	e of Disponetery, crei	Gracef: sition (Nam matory or ot In Crem	e of ther place	9)		ite	20c. Loc	g, Marylacation - City or twood, M	
permit. Pages Department of I Important: If Ite any Injury or of		21. Signature of Funera Service Lice		on-	22 H	Name and	d Addres inald	s of Facility	ral Ho	ome, Inc.			aryland 20904
Physician /Medical Examiner		23a. Cart1. Enter the disease, or con- hock, or Heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each	sed the death. In line. LC Obstru as a consequer	ctive		100		cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Respin	Myocardi ac a consequent catory Fa as a consequen	ilure	arction	n						
ificate be exerginate by the purial-	dical		⊾d. Septio	cemia									
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 ☐ Fetal de at time of deat	eath 3	Ectopic pre Other (spe					2	3d. Date of de Month	elivery Day Year
w requires that been signed by should be deta	۵	Part II. Other significant conditions	contributing to death	but not resultin	ng in the u	nderlying ca	iuse give	n in Part I.		111			o the cause of death? robably 4 ⊠Unknown
	Completed											24b. Were a prior to death?	utopsy findings available completion of cause of
stclan certifi rector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ations OFF	NO utrantian	t 3□ DO/	Othe	g		(Check only o			
F SE F	- 1	27. Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of I (Month,		Bb. Time of Injury		Bc. Injury Work	4 LI Nur	28	e 5 Resid			ecify)
Hospital or Attending 4 hours after death. Funeral Director: Afte tely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	20e. Place of	injury - At home etc. (Specify)	e, farm, str	eet, factory,	office		28	Bf. Location (S City or Tow			ural Route Number,
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hysician: To the be miner: On the basis and manner	of examination	edge, deatl n and/or in	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	l place, ai h occurre	nd due to the o	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	Pu th			29c.	License			2		signed (Mon	
20		30. Name and address of person who						9524 Spring	y Max	vland 20		anuary 2	, 2008
State Registra		Loveen J. Puthumana 31. Date filed (Month, Day, Year) JAN 0 7 20	32 Regi	strar's Signature	е	wad, Si	river	2511118	s, rai	yrand 20	7704		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month 94 ttheh 9-/Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SI 110010 1002016 Colala If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthdey) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) **Funeral** Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Director 133-01-1681 89 Italy Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes ŽXNo Director MD Howard Columbia 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road #1210 21044 USA permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Heelth and Mentel Hygiene. Important: If them 27 is marked other than "natural; or thems 23s any Injury or other fraumatic event; as Medical Experimentals. Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1∑ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 X No Specify: \$ 3 ₩ Widowed 4 Divorced Year or Dates: WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Sculptor 5 4 1 Art 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carlo Peloso Albina Palumbo 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Anna Peloso Moore/daughter 2626 Turf Valley Road Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 01/08/08 Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Box 68760 Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Part II. Other significent contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by completely filled in by the funeral director, page 2 should be detected. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No þ Be Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: Certification: To Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury al Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1881

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

person who completed cause of death (Item 23a) (Type, Print) Kazlowi UfOS Gary

JAN 08

32. Redistrer's Signature

29c. License number

29d, Date signed (Month, Day, Year)

			For	State of Maryland	Department of Health and	Mental Hygien	e
			1 State Registrar		Certificate of Death	Reg. N	2008 01410
	Physici /Medic		1. Decedent's Name (First, Middle, Las JULIA S. PIN	"JTO		2. Date of Death Month	3. Time of Death 5/0 A M
	Examir	ner	CAROLINE HO	SPICE HOUSE	4b. City, Town, or Location of Dea	th 4	CAROUNE
	Funeral Director		5. Social Security Number 6. Sr 1	9X 7. Age (In vrs. last	birthday) If Under 1 Year If Under 24 Hr Yrs. Months Days Hours Mir		9. Birthplace (State or Foreign Country)
	anyland ehow	_	Usual Residence of Decedent 10a. State 10b. County To 1 Column	10c. City, To	own or Location		10d. Inside City Limits 1 ☑ es 2 □ No
	ith the M or 28a-f	by Funeral Director	10e. Street and Number	Di nor	10f. Zip Code	10g. C	Citizen of What Country?
	death w	nerai	404 MR/30K 1	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
9800	72 hours after death with the Maryland Instural', or items 23a or 28a-f ehow Graf Examiner must be notified at	d by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 □ Yes 2 the No Specify:	no moan, etc.)	Specify: WHITE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 ehow many injury or other traumatic event, the Madical Examiner must be notified at ance.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		6a. Decedent's Usual Occupation (Give kind of work done during most of wi life. DO NOT use retired)	orking 16b.	Kind of Business/Industry WN HOME
	be filed v ntal Hygie od other t	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maide	
Maryland	2 should be f and Mental h Is marked of raumatic eve	₽ P	19a. Informant's Name/Relationship (1	(yos. Print) 1	9b. Mailin Address (Stre-Land Number or F	JUWIV Ji Iural Route Number, City	or Town, State, Zip Code)
	es 1 and of Health if itsm 27 ir other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	l same	of Disposition (Name of terry, crematory or other place)	ASTUN 100 20c.	Location - City or Town, State
Baltimore,	t. Pa rtmer rtant rjury		4 Donation 5 Other (Specify 21. Signatule of Funeral Service Licen	CAPI	TOLCEMATORY 0/	08/08 D	OVEK, DE
Ä	Depar Impo				3/15 MARUST FEE	BLAUSER	6,MD 21632
	Physician /Medical		Immediate Cause (Final disease or compositions) Immediate Cause (Final disease or condition resulting in death)	a. Lung Co	not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death 3 MMHK
	Examiner	L	Sequentially list conditions,	Due to (or as a consequence			
	ecuted and transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.			
68760,	icate be executed physician and s the burial-transit	dical E	,	Due to (or as a consequence d.	se or):		
P.O. Box 6	The law requires that the death certific ate has been signed by the ettending pl page 2 should be detached for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 fronths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year
	uires that signed by Id be deta	þ	Part II. Other significant conditions of	ontributing to death but not resulting		23e. Did tobacco	o use contribute to the cause of death?
Vital Records,	e law requ has been je 2 shoul	Completed	Thypertensis			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ital F	ien: The l rtificate ha tor, page	0	25. Was case referred to medical		26 Place of De	performed? 1 Yes 2 N eath (Check only one)	death?
of V	hysici this ce	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	
Division	ng fteil	cation	1 Vatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	p. Time of linjury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No	200. Describe flow in	ury occurred
Divi	± 5 €	Certification:	4 Homicide determined	building, etc. (Specify)	•	City or Town, Sta	
	the Hospital hin 24 hours of the Funeral I upletely filled	Medicai	29a. Certifier (Check only one) Certifying Physics Medical Exem	ysician: To the best of my knowled tiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and plac and/or investigation, in my opinion, death occ	e, and due to the cause(urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within to the comp	ž	29b. Signature and title of certifier	7/1/1/1/1	29c. License number	29d. C	Pate signed (Month, Day, Year)
			30 Name and address of person who d	completed cause of dearn (Item 23)	1) 1005 300 a) (Type, Print)	2	1/01/2008
	Sta	10	31. Date filed (Morth, Day, Year)	MLY 508 /1	KEWILD AVE E	HS1010, (ND 21601
	Registr		JAN 7 200	8 Amos A	And o		

			For State	State	of Marylar				Health Death		lental Hy	•	000	^	<u></u>	
	.8		Registrar	1.11-1-11		00	lillica	le oi	Dealli		2. Date of De	Reg. No	-711	8		
п	Physici		1. Decedent's Name (First, Mid								Month January	eatn Da 02	-	ar 08		of Death 25 pM
W.	/Medi		4a. Facility Name (If not institut	Esther Perin	umher)		4h City	/ Town	or Location	of Death	January		. County of D			r
	Examir	ner			-		45. 01.)	,, 101111,	Bethes			10			merv	
*			5. Social Security Number	rgetown Road	7. Age (In yrs.	last hirthday)	If Unde	er 1 Year			8. Date of Bi	rth	9 1			e or Foreigi
и	Funeral Director		181-09-4467	1□M 2△F	94	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year))	Countr Russ	y)	, or r oroigi
al di	erder der		Usual Residence of Decedent					1		1	000000					
	ylan how at		10a. State 10b. Cour	nty	10c. Cit	ty, Town or Lo	ocation							10		City Limits
	a-f sl	ţ	Maryland Mo	ontgomery					Bethes	da					1 ∑ Y∈	es 2 No
	or 28	Director	10e. Street and Number		· · · · · · · · · · · · · · · · · · ·		10f. Z	ip Code				10g. Cit	tizen of What	Countr	y?	
	23a ust b	<u>a</u>	9707 Old Ge	eorgetown Roa	d, #1103				20814				U.S	.A.		
	ems er m	Funeral	11. Marital Status	12. Was De Armed F	cedent Ever in U	I.S. 13.	Was Dec	edent of ecify Cul	Hispanic Or pan. Mexica	rigin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, W			
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 Never Married 2 M	If Yes. G	2⊠ No live		1 ☐ Yes				,		Specify:			
21215-0036	hours urral"	d b	3 ☑ Widowed 4 ☐ Divorc		Dates:	I 16a Daga	dant'a Ha	ual Oaau	mation			T 405 K			ucasi	111
7	n 72 " nat edica	Completed	(Specify only hig	ent's Education hest grade completed)	16a. Dece	kind of w DO NOT	ork done	during mos	st of work	ing	160. K	and of Busine	ss/Indl	istry	
12	withii ene. than than	E	Elementary/Secondary (0-12 12	2) College	(1-4or 5+)			Iomema	•				Our	Ноп	10	
d 2	filed Hygi ther	ပ္	17. Father's Name (First, Midd	lle, Last)				omeme		er's Name	e (First, Middle	e, Maider		HOI		
Maryland	d be ental ced c	To Be	Charles Nei	renhero						T	da Nerenl	hero				
<u></u>	shoul nd M marl	1	19a. Informant's Name/Relation			19b. Maili	ng Addres	ss (Stree	t and Numb		al Route Numb		or Town, Stat	e. Zip (Code)	
N S	od 2 string at 27 is trau		Stephen Peri								mbia, Ma			, -,	,	
<u>ə</u>	tem tem tem other	0 3	20a. Method of Disposition	en Bon	20b. I	Place of Dispo	sition (Na	ame of	Í		Date	,	ocation - City	or Tow	n, State	
UO	age: ent of nt: If i		1 ⊠ Burial 2 □ Crematio 4 □ Donation 5 □ Other		n State	cemetery, crematory or other place) Judean Memorial Gardens 01/06						0150	land	ı		
Baltimore,	artme ortan Injur		21. Signature of Euneral Servi		Judean Memorial Gardens 01/06/2008 22. Name and Address of Facility							ey, Mary	Tanu			
Ba	permit Depar Impor any Ir		166/							Home, Indenue, Sil	C. Iver S	Spring	Mary	na land	20904	
	Thail.		23a. Part1. Infor the disease,	or complications that	caused the deat								oprang,		Approxim	ate
	Physician		shock, or heart failure. L Immediate Cause (Final												Interval E Onset an	etween d Death
	/Medical		disease or condition resulting in death)	a	umonia (or as a consec	lilence of).								+		
	Examiner				7 (0) 40 4 0011000	1001100 01).										
Q.	S alasa	<u>e</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (or as a consec	quence of):										
	uted d aneit	mi	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1												
oʻ	exec an an rial-tr	Examiner	resulting in death) Last	Due to	o (or as a consec	quence of):								1		
58760,	icate be executed physician and the burial-transit	dical		d												
_	tifica ig ph as th	ledi														
Box	death certifi e attending d for use as	July N	IF FEMALE: 23b. Was decedent pregnant		utcome pf pregn birth 2 D Feta		Ectopic	nroanan	DV.				23d. Date of		,	
	that the death certifiied by the attending I detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No		gnant at time of o		Other (s		~ <i>y</i>				Month		Day	Year
P.0	at the by th	, h	9 🗆 Unknown													
	w requires that the s been signed by the should be detache	by F	Part II. Other significant cond	litions contributing to	death but not res	sulting in the u	inderlying	cause gi	iven in Part	E.			use contribut			
Records,	equir en si ould I	ed		· · · · · · · · · · · · · · · · · · ·							1 🗆	Yes 2	IX No 3 □	Proba	bly 4[Unknowr
GC	law as b 2 sl	Completed									24a. Was	s an opsy	24b. Were	autop:	sy finding	s available cause of
E	The law ate has b	E O									perf 1⊟ Yes	formed?	death	1?	Piction o	000000
Vital	ilcian: Th certificate ector, pag	Be	25. Was case referred to med examiner?	icat					26. Place	e of Deat	h (Check only	one)				
o_ V	Physician: this certific al director,	70	1 ☐ Yes 2 ☒ No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 🗆 🗅	OOA Ot	her: 4□N	ursing Ho	me 5 🖾 Res	idence	6 □Other (S	pecify)		
n O	ding P		27. Manner of Death 1 ☑ Natural 5 ☐ Pen	/1.1-	e of Injury onth, Day Year)	28b. Time o	of	28c. Inju	ury at ork?		28d. Describe	how inju	ry occurred			
Division	Attending r death. ector; After by the fune	Certification:	2 ☐ Accident inve	stigation			M		Yes 2]No						
Ξ	I or Attend after death Director; /	T T		rmined 200. Flac	ce of injury - At h ding, etc. <i>(Speci</i>	ome, farm, st <i>fy)</i>	reet, facto	ory, office	•		28f. Location City or To	(Street al own, State	nd Number oi e)	Rural	Route N	ımber,
Ω	ital c															
	To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medic	ying Physician: To the cal Examiner: On the	basis of examina											e(s)
	the the mple	Med	one)		nner stated.			9c Licen	se number			29d Da	ate signed (M	onth D	lay Vaar	1
	vith con	-	29b. Signature and title of cert	7 ?	. 12.	10	7 "	_0. 2.0611								
•	17/		'LL	Lee	191			-	D26259	-		Jar	nuary 4,	200	18	
	1		30. Name and address of pers					hood-	Massass	land '	2021/-					
	0		Ava A. Kaufmar 31. Date filed (Month, Day, Ye.	·	Registrar's Signa		, bet	nesua	, mary	TallU ,	2U014					
	Sta Registi		JAN O			K do	and s	•								

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEAL)

32 Registrar's Signature

		•	1 - For State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygier	2000	01413
44 36 7	Physici		Decedent's Name (First, Middle, Last) JAMES KINSEY RICHMOND		2. Date of Death Month JAN 7	2008	3. Time of Death 4:10 A ^M
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 19620 WESTERLY AVE. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death POOLESVILLE If Under 1 Year If Under 24 Hrs.	8. Date of Birth	MONTGOM 9. Birth	ERY place (State or Foreign
35	Funeral Director		216-16-2011	Months Days Hours Min.	(Month, Day, Yea	1922	MD
	the Maryla 28a-f ehov	ector		SVILLE	10= (Citizen of What Cou	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	eth with a 23a or	rai Dir	19620 WESTERLY AVE.	10f. Zip Code 20837		USA	
9036	within 72 hours after deeth with the Maryland ane. then "natural", or iteme 23e or 28e-f ehow he Madisal Examinar musi be notified at	d by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Was 2 □ No 1941 - If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp II Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylar if Health and Mental Hygiene. Itam 27 is marked other then "natural", or iteme 23a or 28a-f ehow other traumatic event, The Medical Examinational Learnified at	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) CUTIVE	ang	Kind of Business/Ir	
Maryland	iould be filed I Mental Hygi narked other natic event, I	To Be C	17. Father's Name (First, Middle, Last) JAMES MONTGOMERY RICHMOND, JR.	ELIZAE	e (First, Middle, Maide) BETH THOM	AS KINS	
	and 2 should and Melally and Me			ling Address (Street and Number or Rur 20 WESTERLY AVE			
Baltimore,	a o - -		4 Donation 5 Other (Specify)	ematory or other place)		Location - City or T	own, State PRING, MD
Ball	permit. Pag Department Important: f eny injury o		· W. +3/4	22. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, BA	RNESVILL	E, MD	20838
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	nter the mode of dying, such as cardiac	1,	ase	Approximate Interval Between Onset and Death
94	Examiner	T O	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
8760,	icate be executed physicien and s the burial-transit	ai Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9	₩ O 0	Medic	IF FEMALE:				
.O. Box	that the death certificate ed by the attending phys detached for use as the	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1□Live birth 2 □ Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Đate ol deliv Month	ery Day Year
ords, P	The law requires that the tee been signed by the bage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		o use contribute to	the cause of death?
Division of Vital Records,		Completed			24a. Was an autopsy performed?	prior to co	opsy lindings available ompletion of cause of
Ĭ.	× 50	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie	Othon	th (Check only one) Ome 5 Residence	6 ☐Other (Speci	fy)
ion oi	ding Ph J. After th funeral		27. Manner of Death 1 Natural 5 Pending investigation 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)		28d. Describe how in		,,
Divis	To the Hospital or Attent within 24 hours after death To the Funaral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, s building, etc. (Specify)		281. Location (Street City or Town, Sta	nte) .	
	To the Hospital or within 24 hours after to the Funaral Dir completely filled in	edicai	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as and due (stated. o the cause(s)
)	To the within To the	Me	29b. Signature and title of certifier Patricia Tomsko May, M.	29c. License number D 51916	29d. C	Date signed (Month,	Day, Year) 2008
•	12		me and address of perso, who co pleted cause of digital (Ite 23a), year	e G-100 600	ville 1	nD 208	5.
*	Sta Registr		31. Date filed (Month, Day, Year) / 32. Jegistrar's Signature	berli	/	200	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	٠	1 - For State Registrar	State of Ma	aryland / De C	partme ertifica			R	eg. No.		
Physici		Decedent's Name (First, Middle, La ANNA MAE R	OBERTSON					2. Date of Dea Month January		Year	3. Time of Death 2:00 A. M
/Medio		4a. Fecility Name (If not institution, gi			4b. Cit	y, Town, o	r Location of Deat		4c. County o		
		DEVLIN MANOR NU					RLAND			EGANY	
Funeral Director			1 □ M 2171 F	80 Yrs.	Month	er 1 Year Days	If Under 24 Hrs Hours Min.		Year)	Country)	e (State or Foreigr) SYLVANIA
A THE		10a. State 10b. County		10c. City, Town or	Location					10d.	Inside City Limits
d Dail	ţo	MD ALLE	GANY	CUMBE	RLAND						1 ☐ Yes 2 No
or 28	Olrec	10e. Street and Number			10f. 2	ip Code			0g. Citizen of W	hat Country	?
Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23s or 28s-f show sty injury or other traumatic event, the Madical Examiner must be notified at once.	Funeral Director	1311 E. OLDTOWN				2150			U.S. A	- American	Indian
E E	nue	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💓		3. Was Dec	edent of F ecify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		, White, etc	
o E	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10	1 🗆 Yes	2 X No	Specify:		Specify:	WHIT	Έ
E E		15. Decedent's E	ducation	16a. De	cedent's Us	ual Occup	ation during most of wo	rkina	16b. Kind of Bus		
Mad "	Completed	(Specify only highest gi	College (1-4or 5	i+)	DO NOT	use retire	d)	rking			
ygien t, the	Con		1	H	OMEMA	KER		(F) . A (1) . (1)	HOME		
d oth	Be	17. Father's Name (First, Middle, Las GEORGE KENNETH						me <i>(First, Middl</i> e, PHINE MAR			1
d Mer nark natic	은	19a. Informant's Name/Relationship		10h M	ailing Addre	ec (Strant		ural Route Numbe			
th and					3			CUMBERL		2150	
Heal tem 2 other		KENNETH A. ROBE 20a. Method of Disposition	XISON / SOI	20b. Place of Dis	sposition (A	ame of		Date	20c. Location - 0		
ont of it: If it y or o	Н	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		Cemetery, C	-			9/2009	⊘ πποτ	רווא ג דכוי	MD
ortan ortan injur		21. Signature of Funeral Service Lice		DAVIS M	22. Name	and Addre	ERY 01/0			ERLAND	עניין יי
Impor eny ir		DECORAL PI	Lunchu	nel)				HOME, P CUMBERLA		21502	•
ysician Medical pringi-transit	ai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it also also go or monodiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as	a consequence of):						0	iterval Between nset and Death
been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant al 9 □ Unknown	2 Fetal death	3 □Ectopic 5 □ Other		у		23d. Date Mon	of delivery th Da	ay Year
signed b	þ	Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying	g cause giv	ven in Part I.	23e. Did to	bacco use contri es 2 0N e		cause of death? ly 4 □Unknowr
2 8	Completed				<u>.</u>				sy pi med? di	Vere autopsyrior to compeath?	y findings available letion of cause of
certificate rector, pag	Ö	25. Was case referred to medical					26. Place of De	1 ☐ Yes eath (Check only o			
is cer direc	OB	examiner? 1 Yes 2 10	Hospital: 1 Inpatie	ent 2 ER/Outpa	tient 3	DOA Ott	ner: 4.2 Nursing I	Home 5 🗆 Resid	ence 6 Othe	r (Specify)	
leath. Ior: After this certificate his the funeral director, page	tion: T	27. Manner of Death 1-☐Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Inju (Month, Da	y Yeer) 28b. Tim Inju		28c. Inju Wo 1	ry at rk?]Yes 2 □ No	28d. Describe h	ow injury occurre	ed	
wit in 24 hours after death. To the Funeral Director: After corr pletely filled in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of in	ury - At home, farm, c. (Specify)	street, fact	ory, office		28f. Location (5 City or Ton	itreet and Numbern, State)	or Or Rural R	Route Number,
wit in 24 hours after of To the Funeral Direct completely filled in by	edical		hysician: To the best miner: On the basis o and manner st	f examination and/o							
To the	Me	29b. Signature and title of certifier	, 'n,				se number		29d. Date signed		
4		> BISEL	in AN			D	001756	5	Jen. 7,	2006	r
′ .		30. Name and address of person who		leath (Item 23a) (Ty	pe, Print)	Low	6×1	/1(e	100 2	1501	_
mes				7.00	4 6 19					1 3	

DHMH 17 Rev 1/2001

State Registrar DHMH 17 Rev 1/2001 Thomas Johnson,

JAN

31. Date filed (Month, Day, Year)

311 N. Fourth St., Oakland, Maryland

32. Registrar's Signature

2008

U.S. Capitol

20c. Location - City or Town, State

Catherine Culloty

9446 Grist Mill Drive, N. Ridgeville, OH 44039

Creongia Ave, scit-1-17 silverspring MD20902

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Jan. Bate 8,

Receptionist

20b. Place of Disposition (Name of cemetery, crematory or other place)

the Maryland the Medical Examiner plust be notified at iteme 23a death permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene, Important: if them 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Exercised ADER. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

Mary

10a. State

12

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Jeremiah O'Sullivan

19a. Informant's Name/Relationship (Type, Print)

Christina M. Egan/Niece

Directo

Completed by Funeral

Be

Physician /Medical Examiner

To the Hospital or Attending Physicien: The law requires that the death certificate be executed use as t

Diractor: ,

within 24 hours aft To the Funerel Di completely filled in

Division of Vital Records, P.O. Box 68760

	1 Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	r, crematory or other place) Heaven Cemete	Jan. 8, ery 2008	Silver Sp	ring,Maryland
	21. Signature of Funeral Service Licensee		22. Name and Address of Francis J. (Facility Collins Funera	al Home Inc.	
	23a. Port. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	ot enter the mode of dying, su		orrest,	Approximate Interval Between Onset and Death
caminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of				
olcal E)	d.	Due to (or as a consequence of):			
ysician/medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒No 9 ☐ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	elivery Day Year
ered by Pr	Part II. Other significant conditions contr	ibuting to death but not resulting in t	the underlying cause given in		tobacco use contribute t	o the cause of death?
Complet				24a. Was auto perfe 1 Yes	psy prior to death?	utopsy findings available completion of cause of s 250 No
e o	25. Was case referred to medical examiner?			Place of Death (Check only	опе)	
0	1 ☐ Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3 DOA Other:	Nursing Home 5 ☐ Res	idence 6 Other (Spe	ecify)
ation:	27. Manner of Death 1 Alatural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Tir	me of jury at Work? M 1 □ Yes		how injury occurred	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (City or To	Street and Number or A wn, State)	Bural Route Number,
eolcal	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowledge, or: On the basis of examination and/ and manner stated.	death occurred at the time, d /or investigation, in my opinio	ate and place, and due to the n, death occurred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
M	29b. Signature and title of certifier	3	29c. License nu		29d. Date signed (Mon	th, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sunitea Bhogavill

JAN 0 8 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0^{Day} , **Physician** JAN. Clayton Dalious Rosser 2008 9:15PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Federalsburg Caroline 3865 Smithville Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 30, 1922 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 x M 2 □ F Months Days 85 Mar. 216-12-1009 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 1 ☐ Yes 2x ☐ XNo MD Caroline Federalsburg Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3865 Smithville Road 21632 United States ral", or items 23a Examiner must b Completed by Funeral 12, Was Decedent Ever in U.S. Armed Forces? 1, T.Yes 2 □ No If Yes, Give Year or Dates: 143-46 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🙀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caroline County the 12School Bus Contractor Bd. of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) repartment of Health and Mental F Important: If item 27 is marked out any Injury or other recovery Be Pages 1 and 2 should be nent of Health and Mental Minnie Nagel Paul D. Rosser 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3865 Smithville Rd., Federalsburg, MD 21632 Linda P. Rosser/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 01/05/08 Federalsburg, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee CF5P Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 30 grs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of) Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Physician/Medical attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No in 24 hours after death.

Reference Director: A letely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

DHMH 17 Rev 1/2001

within 24

29a. Certifier (Check only one)

29b. Signature and title of certifier

Syed Ali, M.D.

31. Date filed (Month, Day, Year)

JAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

505

8 2008

and manner stated.

Dutchman's Lane,

32 Registrar's Signature

MD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0046020

Easton, MD 21601

29d. Date signed (Month, Day, Year)

108

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11-2008 Month Physician SARAH CATHERINE RICE 0:16AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 10 N Liberty Street Apt. 207 Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Yrs Apr 23, 1918 MD Director 217-10-1924 89 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ∏Yes 2 ☐ No 28a-f sh notified Allegany Cumberland MD Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with arent of Health and Mental Hygiene. and if item 21 is marked other than "natural", or Items 23a or any or other traumatic event, the Medical Examiner must be a rury or other traumatic event, the Medical Examiner must be a 10 N. Liberty Street Apt. 207 21502 USA Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: 3 Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>radiology department</u> Memorial Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Belva Diehl Alfred Diehl မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14600 Rice Hill Road NE Cumberland MD 21502 Ronald Rice son permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1/16/2008 Hillcrest Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Frineral Service Ocens 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 7 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck or heart failure. List only one cause on each line. Immediate Cause (Final ORONAR DIZEASE **Physician** disease o condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERT 210 N Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò BRILL 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2★No 24a. Was an certificate has tirector, page 2 s autopsy performed? Yes 22 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home ျှ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director;
completely filled in by the f

Certification: 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 130

10062929

CUMBERLAND

DEMNZYLVANIA.

			State of Maryland / D	Pepartment of Health and M Certificate of Death	•	2000	01419
	Physici		1. Decedent's Name (First, Middle, Last) Robert A. Roche		2. Date of Death Month January	Day Yeer 2. 2008	3. Time of Death $11 : 30 \mathrm{p}^{\mathrm{M}}$
	/Medi Examir		4a. Fecility Name (If not institution, give street and number) 500 State Street	4b. City, Town, or Location of Death Delmar	January	4c. County of Deeth Wicomico	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth		8. Date of Birth (Month, Day, You Jan. 6, 1	9. Birthp	olace (Stete or Foreign ntry) ington D.C.
	e Maryland Ba-f ehow	Director	10a. State 10b. County 10c. City, Town MD Wicomico Delmar	or Location		1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Itame 23a or 28e-f show event, If a Medicial Examinar must be notified at	by Funeral	10e. Street and Number 500 State Street 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 No 1949— 1 Yes, Give Year or Dates: 1971	10f. Zip Code 21875 13. Was Decedent of Hispanic Origin? (Spelif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify: Decedent's Usual Occupation	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Americ Black, White, Specify: white.	ean Indian, etc. Lte
	filed within 72 Hygiene. other than *nai	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 Chi	(Give kind of work done during most of worki life. DO NOT use retired) Lef Warrant Officer	U	.S. Marine	
Maryland	d Men marke	To Be	17. Father's Name (First, Middle, Last) Edward Charles Roche 19a. Informant's Name/Relationship (Type, Print) 19b.	18. Mother's Name Frances Mailing Address (Street and Number or Rura			Code
	1 and 2 Health a tem 27 ii		Eleanor Roche (Wife) 50	00 State Street Del	lmar, Mar	yland 2187 c. Location - City or To	5
Baltimore,	permit. Pages Department of Important: If II any injury or once.		'4 □ Donation 5 □ Other (Specify) Cremato 21. Signature of Funeral Service Licensee	ry of Delmarva Jan. 4 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street	4,2008 De Delmar		
8/60,	Physician //Medical Examiner the privative in the privat	dicai Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart affilire. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.	Les Diseuse and Instrum "Hellots	or respiratory arrest.		Approximate Interval Between Onset and Death
O. BOX 6	res that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ory Day Year
rds, P	- w -	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		co use contribute to the	
II Record	The law ate has b page 2 sh	Completed			24a. Was an autopsy performed	prior to cor death?	psy findings available impletion of cause of
sion of Vital	Attending Physician: Thr r death. sctor: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1			e 6 ⊡Other (Specif) njury occurred	1)
DIVISI	tel or Attendii rs after death. el Director: A ed in by the fu	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, fame building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occurre	ed at the time, date	and place, and due to	the cause(s)
1 i	2 1 2 5 1 4 5	1	29b. Signature and the of certifier	29c. License number H 54827		Date signed (Month,	Jay, Year)
1.	ואל		30. Name and address of person who completed cause of death (Item 23a) (T	Salisbury,	md. 2	1804	
1	Sta Registr		JAN U 7 2008	port			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 1214 James Polk Scott January 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Director 83 June 6, 1924 Maryland 220-18-6940 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event than "Martin-1". 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Maryland Ceci1 E1kton 10g, Citizen of What Country? 10e. Street and Number 10f. Zin Code 170 Carters Mill Road 21921 United States Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 👿 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Industrial/Commercial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be T. Bayard Scott Ella David 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan C. Scott/Wife 170 Carters Mill Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gilpin Manor
Memorial Park Date 20a. Method of Disposition 20c. Location - City or Town, State January 21 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2008 Elkton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29b. Signature and title of certifier

ino this

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32: Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar		State of Ma	ryland	-	oartment o e <i>rtificate d</i>			ental Hy	giene Reg. No	-2 0 0 2	0142
	M K	п	Decedent's Name	(First, Middle, Lasi	")				, Doan	,, 	2. Date of D	eath		3. Time of Death
	Physici /Medic		Tho	omas I	Larner	Sta	rkey	7			Month Janua:	ry 1	2, 2008	11:41 A M
	Examir		4a. Facility Name (If I	-	street and number)		_	4b. City, Tow				40	c. County of Deat	n
	ساينة ومايده مادها الماسية الحرور		5535 Mors 5. Social Securify Nu		7 000	(In ura la	ast birthda	Prince			8. Date of Bi	rth	Calvert	
	Funeral Director		216-40-85	- 1 t	M 2□F	64	Yrs.	Months Da			(Month, D	ay, Year -194	3 Wash	nplace (State or Foreign untry) D.C.
<i>ai</i> .	pu ,		Usual Residence of D	Decedent 10b. County		10c City	, Town or	Location						10d. Inside City Limits
	faryla shov ed at	ō	MD.	Calve	rt	Toc. Oity	, TOWIT OF	Prince	a Frac	arick				1 ☐ Yes 2 ☑ No
	the A	Director	10e. Street and Num		LL			10f. Zip Coo		ELICA		10g. Ci	itizen of What Co	
	h with		5535 Mors	sell Road					20678				USA	
	ems 2	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S	S. 13	3. Was Decedent If Yes, specify (of Hispanic (Origin? (Spe	cify Yes or N	0-	14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Fu	1 ☐ Never Marrie 3 ☐ Widowed 4	~ -	1 NYes 2 N If Yes, Give Year or Dates: 1			1 ☐ Yes 2 🛱					Specific:	nite
21215-0036	2 hour atural cal Ex	ted b		15. Decedent's Edu	ucation	- 005	16a Dec	cedent's Usual Oc	cupation			16b. k	Kind of Business/	
215	thin 7; e. an "n Medl	Completed	(Specification)	fy only highest grad dary (0-12)	de completed) College (1-4or 5-	+)		ve kind of work do . DO NOT use re	ne during m tired)	ost of workin	ng			
	led wi lygien her th		47 February 15	Clock Middle (Lock)	5+		atto	orney	10.140	ther's Name	/Firm & Balantal	1 00		actice law
and	intal Fed out	Be	17. Father's Name (F		Starkey				18. MO	Lucia	(First, Middle	e, maidei	*	Mawley
Maryland	2 should be filed v n and Mental Hygie Is marked other t raumatic event, th	10	19a. Informant's Nar				19b. Ma	iling Address (Str	eet and Nun			ber, City	or Town, State, 2	
	1 and 2 Health a tem 27 Is		Susan L.	Starkey,	spouse		30]	Industry	Lane,	Princ	ce Fre	deri	ck, MD 2	20678
ore,	of He fitem		20a. Method of Dispo	osition	Removal from State	20b. Pl	ace of Dis	position (Name o rematory or other	f place)	D	ate	20c. L	ocation - City or	Town, State
Baltimore,	: Pages tment of I tant: If Ite		4 ☐ Donation	5 ☐ Other (Specify,)	Met	ropo]	litan Cre			14-08			kandria, VA
Bal	permit. Pages Department of Important: If It any injury or o		21. Signature of Fun	eral Service Licens	see			22. Name and Ad		ita			al Home,	
			23a. Part1. Enter the	e disease, or comp	lications that caused	the death	. Do not e						s, MD 20	Annroximate
	Physician		Immediate Cause (F	inal	one cause on each lin	e.	Store	ae cho	TANI	. ~	hetai	rtu	10	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)		a. Due to (or as a	a consequ	ence of):	1,5	HOM	<u> </u>	em	re d	ve no ease	Severa
	Examiner		Sequentially list cond	ditions.	b							0.		Jears.
. 1	pe:	Examiner	if any, leading to imn cause. Enter Underl Cause (Disease or in that initiated events	mediate	Due to (or as a	a consequ	ence of):							
mg	execut and al-tran	xan	that initiated events resulting in death) La	ast	c Due to (or as a	a consequ	ence of):							
68760,	cate be executed physician and the burial-transit	dical		l	d									
	ntifica ng ph	Medi	IF FEMALE:									T		
Box	ath ce attendi	ian/	23b. Was decedent print the past 12 n	pregnam	23c. If yes, outcome p 1□Live birth	2 ☐ Fetal	death 3	B □Ectopic pregn					23d. Date of del Month	ivery Day Year
P.0.	the de y the s ched 1	Physician/Me	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4□Pregnant at 9□Unknown	time of de	eath :	5 ☐ Other (specif)	//					
	s that ned by	by Ph	Part II. Other signific	cant conditions oc	ontributing to death bu	it not resu	Iting in the	underlying cause	given in Pa	rt I.	23e. Did	tobacco	use contribute to	the cause of death?
rds	equires en sig ould by										1 🕅	Yes 2	2□No 3□Pr	obably 4 □Unknown
ecc	law re as be 2 sho	Completed									24a. Wa	opsy	prior to o	topsy findings available
<u>e</u>	: The cate h	Con		-							peri 1□ Yes	ormed?	death?	2 No
Vit	siclan certifi rector	Be	25. Was case referre examiner?		Hospital:				Other:		(Check only			
o	y Physer this eral di	: To	1 ☐ Yes 2 📉 N 27. Manner of Death		1 ☐ Inpatier 28a. Date of Injur	у	ER/Outpat 28b. Time	0 2011	4∐ Injury at Work?		ne 5 XI Res 8d. Describe		6 □Other (Speury occurred	cify)
ion	ath. r: Afte	atior	1 🌠 Natural 2 🗋 Accident	5 ☐ Pending investigation	(Month, Day	Year)	Injun		Work? 1 ☐ Yes 2	□No				
Division or Vital Records,	r Atte ter dea Irecto I by th	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of inju building, etc	ry - At hor :. (Specify	me, farm,	street, factory, off	ice	2	8f. Location City or To	(Street a	and Number or Ru te)	ural Route Number,
	pital o urs aft eral D		00- 0-45	17 Comitalno Div	releiant To the heat o	of many longue	uladea de	ath conversed at th	a time alote	and place	and place to the		(a) and according	-1-1-1
	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)	2 Medical Exam	vsician: To the best of iner: On the basis of and manner sta	examinat ted.	ion and/or	investigation, in	ny opinion,	death occurr	ed at the time	e cause(e, date ar	nd place, and due	to the cause(s)
	within To the compl	Me	29b. Signature and t	itle of certifier	^				ense numbe			29d. D	ate signed (Mont	
) del	myor	ran			1)0	027	109)	14/08	3
	20+1				ompleted cause of de				7	, ,				2620
	Sta	to	Zahir You		., 2417 Sc	As Oleman			aa, No	orth,	Huntin	gtow	\mathbf{m} , \mathbf{MD} 20	1639
H	Registi			N 2 3 200	E2	13		sel.						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) ^{Day} 4, 2008 **Physician** Catharine Nancy Spehrley January 8:00a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 40 Elk Lane Elkton Cecil If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Mache | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🔀 F Yrs. 71 19,1936 Director 181-26-8427 October Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2X No Director MD Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 40 E1k Lane 21921 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner D & J Vending Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental F 7 is marked otl Earl Nelson Davis Catharine E. Allen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is any injury or other trausonce. Linda S. Gregg/Daughter 18 Pine Valley Rd., Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State J □ Other (Specify)

The transfer of the second se January 4 ☐ Donation 5 ☐ Other (Specify) Ferris Inc. West Chester, PA R.A. 2008 22. Name_and Address of Facility Andrew G. Gee Funeral Home 259 East Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MAUMONIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown by signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ HY PRITENCION 1 Tes 2 No 3 Probably 4 Unknown Completed THEVOSCHIOVIS 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 2 No certificate Der lipe demiA 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 Could not be determined 3∏ Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number D33510 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0-1) wwell 10 mi People, 31. Date filed (Month, Day, Year) State Registrar

			For	State o	f Maryla		epartment of		Mental Hy	/gien	ie	
			1 - State Registrar				Certificate o	f Death		Reg. N	0.2008	011.23
		77	1. Decedent's Name (First, Middle, L.	ast)					2. Date of De		- 	3. Time of Death
	Physici		Mary Louise S	cutt					Janu:		3, 2008	5:10 a M
	/Medic Examir		4a. Facility Name (If not institution, gi		mber)	-	4b. City. Town	, or Location of Deat			c. County of Death	
	Examir	er	Suburban Hospit					hesda				
				Sex	7. Age (In)	vrs last hirt			8. Date of Bi	rth	Montgo:	place (State or Foreign
	Funeral			1 □ M 2X□ F	range (m)	59	Months Day		(Month, D	a <i>y, Ye</i> a	ir) Coui	ntry)
	Director		578-66-3019 Usual Residence of Decedent			59			May 5,	194	±8 wasn	ington, DC
	and w		10a. State 10b. County		10c.	City, Town	or Location					10d. Inside City Limits
	lary!	5										1 ☐ Yes 2 ☐ No
	ne M 8a-f otifie	Sct	Maryland	Montgor	nery		Silver Sp			10.0		Α.
	e n	Director	10e. Street and Number				10f. Zip Cod	9		10g. C	Citizen of What Cou	ntry?
	ath v		9102 Warren Str				20910				USA	
	r de	Funeral	11. Marital Status	12. Was Dec Armed Fo	orces?	n U.S.	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puer	Specify Yes or Note to Rican, etc.)	0-	14. Race - Americ Black, White,	
ي	or if		1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	ve		1 ☐ Yes 2 ☐ 1	lo Specify:			Specify: Whi	+ 0
Š	ers ours	d by	3 Widowed 4 Divorced	Year or D	ates:							
7	72 h	ete	15. Decedent's E (Specify only highest g	ducation rade completed)		16a.	Decedent's Usual Oc (Give kind of work do life. DO NOT use ret	cupation ne during most of wo	rking	16b.	Kind of Business/In	dustry
2	Me Me	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use ret	ired)	-			
2	ygier the	Ö		1		Ad	ministrati				Clerical	
7	vent se file	Be Completed	17. Father's Name (First, Middle, Las	t)				18. Mother's Na	me (First, Middle	e, Maide	en Surname)	
<u> </u>	Aent Aent e tree tree tree tree tree tree tree	ဥ	Joseph Felix McD	ermott				Dorothy	Agnes He	011e	enback	
2	sho sho ma		19a. Informant's Name/Relationship	(Type. Print)		19b.	Mailing Address (Stre	eet and Number or R	ural Route Numi	ber, City	or Town, State, Zij	o Code)
Σ	nd 2 alth a 27 is r tra		Joseph Scutt/ Hu	sband		91	02 Warren	Street, S	ilver S	prin	ng, MD 20	910
٥	tem tem		20a. Method of Disposition		20	b. Place of	Disposition (Name of	niana) I T-	Date	20c.	Location - City or T	own, State
altimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	☐Removal from			y, crematory or other	!	n. 8,	77.		771 1 1
<u> </u>	artme		21. Signature of Funeral Service Lice		141	ecrop	olitan Cre		800	ATE	exandria,	virginia
a a	Department of the property of the property is an an an an an an an an an an an an an		A LOVING LO	100	p		Francis	J. Collin				
			CO Post Standard disease and		~	teeth Dee					er Sprin	g, MD 20901
- 1			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	one cause on e	each line.	ieain. Do n	ot enter the mode of t	aying, such as cardia	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a Lun	Canc	er						6 Months
	/Medical		resulting in death)	Due to	(or as a con	sequence o	f):					
B	Examiner		Sequentially list conditions	b								
<i>A</i> •		ner	if any, leading to immediate cause. Enter Underlying	Due to	(or as a con	sequence o	f):					
12	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jiease or nyury that initiated events	C							-	
47	an ar	Ë	resulting in death) Last	Due to	(or as a con	sequence o	f):					
68760	ysici	edical		d								
	tifica g ph as th										L	
Sox S	eath certiff attending for use as	2	iF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			· -				23d. Date of deliv	ery
_ m	atte for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No		birth 2□f nant at time		3 ☐ Ectopic pregna 5 ☐ Other (specify)				Month	Day Year
_ ` c	the c y the	Physician/M	9 Unknown	9□Unkn	own							
۵	uires that the de signed by the a Id be detached i		Part II. Other significant conditions	contributing to d	eath but not	resulting in	the underlying cause	given in Part I.	23e. Did	tobacco	o use contribute to t	the cause of death?
L. L.	sign d be	d by							1社	Yes	2 No 3 Pro	bably 4 ☐Unknown
7 9	w requir been si should	Completed							04- 146-		1000	
ě	sician: The law certificate has t irector, page 2 s	F							24a. Was	s an opsy formed?	prior to co	opsy findings available empletion of cause of
	Th cate pag	Ö							1□ Yes	21	No 1 ☐ Yes	2□ No
May or Vital	sian: ertific ctor,	Be	25. Was case referred to medical examiner?						ath (Check only	one)		
23	ysic dire	은	1 ☐ Yes 2X No	Hospital: 12	Inpatient 2	2 🗌 ER/Out	patient 3□ DOA	Other: 4 ☐ Nursing I	Home 5 ☐ Res	idence	6 ☐Other (Speci	ify)
	ig Pl	Ë	27. Manner of Death 1 KN atural 5 ☐ Pending	28a. Date	of Injury hth, Day Yea	28b. T	ime of 28c. In ijury V	njury at Vork?	28d. Describe	how in	jury occurred	
Je jo	ath. Pr: Af	aţio	2 ☐ Accident investigation	on				☐ Yes 2 ☐ No				
cutt	Atte	iţi	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	20e. Place	of injury - A	At home, far	m, street, factory, offi	се	28f. Location City or To	(Street	and Number or Rur	al Route Number,
¹Ŭ Ē	a affe	Certification:	. <u> </u>	Dulid	mg, 0.0. (<i>Op</i>	cony,			Only of 10	m, or	110)	
1)	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ial (death occurred at the					
	ne Ho 124 ne Fi	Medical	(Check only 2 Medical Exa one)	and man	ner stated.	nination and	d/or investigation, in n	ny opinion, death occ	urred at the time	e, date a	and place, and due	to the cause(s)
	Fo th	Me	29b. Signature and title of certifier				29c, Lice	ense number		29d. [Date signed (Month,	, Day, Year)
	10		tela I	WV	٨	10	D5	1616			January 3	3, 2008
			30. Name and address of person who	completed caus	se of death ((Item 23a)	Type, Print)				_	
			Nelson Kalil, MD				venue, #13	00, Chevy	Chase,	MD	20815	
	Sta	te	31. Date filed (Month, Day, Year)	4907	3egistrar's S							
	Registr	- 1	JAN 0 7 200	18		KA	male					
				400								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 5Day **Physician** Month 2008 7:25 Рм Mary Louetta Smith /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Atlantic General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Yrs. Kansas 513-14-4911 83 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow the Mudical Examiner must be notified a Berlin 1 □ Yes 2 No Worcester MD Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 412 S. Main St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 | Yes 2 | No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: þ White 3 Widowed 4 XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Brown Edward Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Heelth 412 S. Main St., Berlin, MD 21811 John E. Smith / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Eremation 3 Removal from State = 5 1/7/2008 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 coll ma 234 Part 1. Enter to dis-shock, or heart face to or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. Approximate Interval Between Onset and Death Cardisvasculer Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Drinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Funaral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: 1 ☐ Inpatient 2 ★ ETVOutpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide within 24 hours e To the Funarail Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Daye signed (Month, Day, Year) D28269 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Coastal Hydrey Fewert Feberal, De 19944

N

DOD: 115/08

DOB. 4 Jaulay

554 513-14-4911

mith, Wany law

State Registrar

31. Date filed (Month, Day, Year) JAN 0 8 2008

Nicholas Goradulin

32. Pegistrar's Signature

	,	1 - State of Maryland / De	partment of F ertificate of			giene 0 0	8 01425	
Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Anthony J. Skrivanek 4a. Facility Name (If not institution, give street and number)	Ab City Town (or Location of Death	2 Date of Dea Month Jan 1		3. Time of Death $10:25A$	
Examin Funeral	er	National Lutheran Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 098-01-4544 1	ROCK	ville	8. Date of Birt (Month, Day June 6	Montgo		
Director	or	Usual Residence of Decedent , 10a. State 10b. County 10c. City, Town or			pulle o	,1910	10d. Inside City Limits X Yes 2 No	
with the M 3a or 28a-f	Funeral Director	10e. Street and Number 9701 - Veirs Drive	10f. Zip Code 208	350		10g. Citizen of W	hat Country?	
interior e, interior in the first cooperate from the many and armont of health with the Maryland armont of health and Mental Hygiene. A contant: if item 27 is marked other than "natural", or itema 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at a.	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forcas? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of H If Yes, specify Cub		ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. White	
d within 72 ho giene. Ir than "natur The Medical	Completed	(Specify only highest grade completed) (Gillife Flementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occup ive kind of work done o. DO NOT use retire thanical	during most of work d)		16b. Kind of Bus	,	
yioning E. I. Suld be filed with Mental Hygiene srked other than stic event, the stice of the st	To Be C	17. Father's Name (First, Middle, Last) Anton Skrivanek		18. Mother's Name		Maiden Sumame esault		
and 2 sho ealth and I m 27 is m		Barbara Windsor-Daughter 16	Turnham	La., Ga	ithers	burg, Mo	1. 20878	
Dalling C, IV Department of Health mportant: If Item 27 any injury or other tr		1 Burial 2 Acremation 3 Removal from State Metropol 4 Donation 5 Other (Specify)		ematory-	1/2/08		city or Town, State	
permit. Pag Department important: i		23a. Part1. Enter the disease, or combications that caused the death. Do not shock, or heart failure. List only/ope causelon each line.	22. Name and Addre Hysons 2222-V enter the mode of dyn	g Co. Misconsi	n Ave.	, NW , Wa	Approximate Interval Between	
Physician /Medical Examiner per execution and prival-transition and prival-transition and prival per execution and per e	Examiner	D.	tremi	-1 0	erlar ep Ve	e dise.	Onset and Death stleven bosig	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical		3 □Ectopic pregnanc 5 □ Other (specify) _	zy		23d. Date Mon	o of delivery th Day Year	
w requires that been signed t	Ď	Part II. Other significent conditions contributing to death but not resulting in the	aunderlying cause gr	ven in Part I.			cco use contribute to the cause of death? 2 No 3 Probably 4 Munknown	
n: The law ricate has be or, page 2 sh	e Completed	25. Was case referred to medical		26. Place of Deal	1 Tes	ormed? d	Vere autopsy findings available fior to completion of cause of eath? Yes 2 No	
nding Physicia th. r: After this certi e funeral directo	on; To B	examiner?	e of 28c. Inju	her: 4X Nursing Ho	ome 5 🗆 Resi	dence 6 Othe		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the the	Certificati	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (City or To		er or Rural Route Number,	
the Hospi nin 24 hour the Funer npletely fill	Medical	29a. Certiflier (Check only one) Certifying Physician: To the best of my knowledge, drawn one) Certifying Physician: To the best of my knowledge, drawn one) Certifying Physician: To the best of my knowledge, drawn one) Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my			date and place, a		
5 1 5 0 0	2		2 06	-		L / L/		
(3)		30. Name and address of person who completed cause of death (Item 23a) (Tyl Dr. Sharon Yang - 6 Executive	Park Ct	., Germa	ıntown	Md.		
Sta Registi		JAN 0 4 2008 Single State of the state of th						

DHMH 17 Rev 1/2001

ORIGINAL

		590	1 - For State Registrer	State of Mar			of He	alth and		giene (8 (8	01426	
	Dhusisi	(B)	1. Decedent's Name (First, Middle, Last,						2. Date of Dea Month	ith Day	Year	3. Time of Death	
	 Physicis /Medic 		Laster Clifton Click Cr							January 3, 2008 8:4			
	Examin		4a. Facility Name (If not institution, give			4b. City, T	own, or L	ocation of De	ath	4c. County	of Death		
14		Julia Manor Health Care Center Hagerstown 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of								Washington			
	Funeral Director		214-28-7444	D a	n yrs. last birtho	Months		Hours Mi		, Year)	9. Birthplac Country Mary	ce (State or Foreign v) land	
	and		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town of	or Location					100	J. Inside City Limits	
	Maryl f sho	ō	Maryland Washingto	n	Hager	stown						1√2 Yes 2 No	
	the 28a	Director	10e. Street and Number			10f. Zip (Code			10g. Citizen of W	hat Country	v?	
	3s or	ā	47 Manor Apartmen	ts - A3			1740			U.S.A		,	
	ms 2	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was Decede	ent of Hisp	anic Origin?	(Specify Yes or No- erto Rican, etc.)		- Americar		
21215-0036	be filed within 72 hours atter death with the Maryland and Hygiene. I de Hygiene. I de Ather than "netural", or items 23a or 28a-f show atter than "netural", or items 23a or 28a-f show avent, the Medical Eraci, art most ke rediffed a	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1		If Yes, specif		Mexican, Pue Specify:	erto Rican, etc.)	Specify.	k, White, etc Whit		
9	72 ho	Completed	15. Decedent's Edu	cation	16a. D	ecedent's Usual Give kind of work	Occupation	on		16b. Kind of Bu			
21	within 7 ene. than "r	Jple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)		fe. DO NOT use	retired)	ing most of w	orking	Montgon	-	-	
	e filed within al Hygiene. I other than vent, the Me	Co	8th		Во	iler Me				School		m	
p	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)				18	8. Mother's N	ame (First, Middle,	Maiden Sumam	9)		
yla	should be and Mental marked o	မ	Emerson Danie						rtie R.	Sirk			
, Maryland	nd 2 lith a 27 is r tra		19a. Informant's Name/Relationship (Ty Ida E. Slick – Wi			Manor Address (- A3, Ha	r, City or Town, . agerstow			
Baltimore,	ges 1 a it of Hea if item or othe		20a. Method of Disposition		20b. Place of D	isposition (Name crematory or oth	e of ner place)	I	Date	20c. Location -	City or Town	n, State	
<u>Ĕ</u>	Pages nent of ant: If it ary or o		1 XBurial 2 ☐ Cremation 3 ☐ P `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Lisbo	n Cemete	ery	Jar	8, 2008	Lisbon	, Mar	yland	
at	pemit. Pag Department Importent: I any injury o		21. Signature of Pyneral Service Lipens	99 5/., -)	22. Name and		of Facility					
_	89 5 8 9		Hovert L	Willian	ns	Moleswor 26401 R	rth-W	Villian Road	ns P.A., I	Funeral	Home	20872	
	Pnysician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line. Due to (or as a c	u ol	estruti	of dying,	such as cardi	ac or respiratory and	rest, mary 1	PE	Approximate Interval Between Disset and Death Lyck S	
8760,	law requires that the death certiticate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of)	trac	(- I	Enfer	tren			15 days	
P.O. Box 6	that the death certilic ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								ate of delivery onth Day Year		
	luires that n signed t ild be det	þ	Part II. Other significant conditions cor	stributing to death but n	ot resulting in th	e underlying cau	use given	in Part I.		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unkno			
00	w requir s been si should	lete							24a. Was a	ın 24b. W	ere autons	y findings available	
al Re	The ste h	e Completed	25. Was case referred to medical						autop: perfor 1 Yes	medi? d 22 No 1	nor to comp eath?	oletion of cause of ☐ No	
⋚	sicie certi irecto	o Be	examiner?	ospital:	0 □ ED/0	2 DO	Other	. V	eath (Check only or		(0()		
Division of Vital Records,	문 등 등	-	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpa 28b. Tim aar) Inju		c. Injury at Work?			me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Divis	- 2.5	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm Specify)	, street, factory,	office		28f. Location (S City or Town	treet and Numbe n, State)	or Or Flural F	Route Number,	
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	edical C	29a. Certifier 1 Certifying Physical (Check only one)	sicien: To the best of m ner: On the basis of exa and manner stated	amination and/o	r investigation, i	n my opini	ion, death oc	curred at the time, d	ate and place, a	nd due to th	ne cause(s)	
	To th within To th somp.	Zee .	29b. Signature and title of certifier		<u> </u>	29c.	License n	umber	2	9d. Date signed	(Month, Da	ıy, Year)	
	. ^		· Mensey	4 mas	7 36	P	D20	8365)	1-4	6	8	
4	M		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Ty	pe, Print)	veel	- Ha	gordoru	1 19	021	746	
	Stat	te	31. Date filed (Month, Day, Year) JAN 0 8 200	32 Registrar's	Signature	1. 11.			0 -010			· U	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1, 2008 James Donald Simmons 12:01 A M January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 951 Seton Drive, Apt 3 Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1**∑**M 2□F 82 219-14-6842 11/23/1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d Inside City Limits Allegany Cumberland 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 951 Seton Drive, Apt 3 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 X Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1944_ 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 Divorced 1967 White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 MSgt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin Simmons Bessie Lee Strawderman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene M. Simmons / Wife 951 Seton Drive, Apt 3, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Vet. Cem @ Rocky Gap 1/4/2008 Flintstone, MD MD 21. Sicnorure of Funeral Service 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final acute cerennu one month disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

"natural", or items 23a or 28a-1 sn edical Examiner must be notified

traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic even."

filed within 72 hours after death with Hygiene.

3altimore, Maryland 21215-0036

Director

Funeral

þ

Completed

the burial-tra physician as attending p for use as ed by the a been signed by should be detach cate has b

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

or Attending Physiclan:

Hospital

To the I

certificate

this

After

Examiner Physician/Medical <u>م</u> Completed director, Be 2 funeral Certification: Volume...
within 24 hours after occur.
To the Funeral Director. Aft

Medical

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24a. Was an autopsy perform 2 **X**No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 🔲 Yes 2 X No

25. Was case referred to medic examiner?
1 ☐ Yes 2 💢 No
27. Manner of Death

1 Natural 2 Accident 5 Pending investigation 3 Suicide

6 Could not be determined 4 Homicide

1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Injury at Work?

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

woworkshi

29c. License number D0055325 29d. Date signed (Month, Day, Year) January 2, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop Walsh Drive, Cumberland, MD Wonsock Shin, M.D.,

31. Date filed (Month Day Year)

32. Registrar's Signature

2+

nas

State Registrar

08-00131 Je

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jerry Stansbury	1.	For State	State of	Maryland	d / Depa	rtment o	f Health	and l	Menta	l Hygiei	ne Reg.	No. 20	00 011.2
Physician		eqistrar . Decedent's Name (First, M	iddle,Last)			- Intouto o					e of Death		3. Time of Death
Physiciar Medical Examin	.,,	Jerry Stan								Jar	nth D. Nuary 5, 2		0747 hrs
3 Charles	4	la. Facility Name (if not insti			er)		4b. City, Tow		cation of E	Death		4c. County of Dea	
* *		Anne Arundel Med				the blade days	Annapo		If Under 2	24Hrs 8 D	ate of Birth	MM/DD/YYYY) 9. B	
Funeral Director		5. Social Security Number	6. Sex		Age (In yrs. la		If Under	Days	Hours	Min.		Fore	ign
Director		214-62-162 Jsual Residence of Decede		2F		50 Yr	S.			N	ov 28	1957	Maryland
any		10a. State 10b. Cou			10c. City,	Town or Loca	tion						10d. Inside City Limits
* .	<u>-</u>	Maryland An	ne Ar	unde1		Glen	Burni	e					1 Yes 2 X No
Sanf s	Director	10e. Street and Number					10f. Zip C				10g	. Citizen of What Co	ountry?
with the Mary ans 23a or 28a be notified at		412 Valian						061		0 / 0i6	Yea or No	USA	erican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2	Married 1	2. Was Deced Armed Force		.S. 13. W	as Decedent Yes, specify	of Hispa Cuban, M	Mexican, F	Puerto Ricar	, etc.)	White, etc.	
er dear		3 Widowed 4	Divorced If	Yes Yes, Give Year	2 X No	1	Yes 2 🔀	No	specify:			Specify: B1	ack
urs aft tural"	ام ام	15. Decedent's Education	Lor	Dates:	completed)	16a. Decede	ent's Usual O	ccupatio	n (Give kir	nd of work d	one 1	6b. Kind of Busines	s/Industry
3 72 hor n "na al Ex	Completed	Elementary/Secondary (0	-12)	College (1-4	or 5+)	"		•	O NOT U	se remou		N/A	
5-0036 fied within 77 Hygiene. I other than the Medical	Ĕ	12th_		0		<u> </u>	Disab		Mother's	Name (Firs	Middle, Ma	aiden Surname)	
15-C filed v I Hygi d oth		17. Father's Name (First, Milliam C.		chury	Sr			- ["			. Joh		
2121 Mental be find marked ic event,	To Be	19a. Informant's Name/Rela			<u> </u>	19b. Maili	ng Address	(Street	and Numb	er or Rural	Route Numb	er, City or Town, Sta	ate, Zip Code)
MD d 2 shot the and 1 is a 1 i		Vivian Sta	nsbur	y(Motl	ner)	412	Valia	nt	Circ			Burnie,	Md. 21061
Te, Land I and Healt Healt fitem		20a. Method of Disposition 1 X Burial 2 Cren	estion 3	Removal from	State 295	Place of Disp	osition (Name offier place)	of cem	etery,	Dat	e	20c. Location - City	or rown, State
MOI Pages ent of ent of unt: Il		4 Donation 5 Oth		TCHOVAL IIO	Me	emoria				1-14-		Annapo1	
Baltimore, permit. Pages I an Department of Hee Important: If ite	1	21. Signature of Funeral Se	rvice License	9		27A	Mame and e	46.84	of Facility	Sons	Mortu	ary, P.	A. 1401
		Yarry S Ag 23a. Part I. Enter the disease	ese M	oo483	sed the death						-		Approximate Interval
Physician /Medical		failure. List only one of	ause on each	line.									Between Onset and Death
xaminer		Immediate Cause (Final dis or condition resulting in de-	ease a. <u>H</u> ath) Du	vpertens	onsequence	eroscler of):	otic car	U1QV	ascura	ar dise	156		
		Sequentially list conditions	b			 							
	iner	if any, leading to immediate cause. Enter Underlying C	ause	e to (or as a o	consequence	of):							
.=	Examin	(Disease or injury that initial events resulting in death)	160	ie to (or as a d	consequence	of):							
tal Records, P.O. Box 68760, rian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	alE		d						**		<u> </u>		
O, be ex	edical	X UNPENDED		#23a.PI	I.27 per	rME.g875	, 1/24/0	17 8C	1			23d. Date of deli	very
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate Funeral Director: After this certificate has been signed by the attending phys lely filled in by the funeral director, page 2 should be detached for use as the b	Physician/Me	IF FEMALE: 23b. Was decedent pregnar past 12 months?	nt in the	1 Live bir	utcome of pre- th		Fetal death	3	Ectopic	pregnancy		Month	Day Year
X 60 th cert	sicia	past 12 months?	Linknown	7 🛁	nt at time of d	leath 5	Other (Spec	ify)					
. Bo he dea y the a	hys	Part II. Other significant of		9 Unknow		resulting in th	e underlying	cause g	iven in Pa	rt I.	23e. Did to	bacco use contribut	e to the cause of death?
P.O. es that the igned by be detac	by	renal fail					, ,	Ĭ			1 Yes	2 No 3	Probably 4 🗹 Unknown
ds, land be wild be	Completed	TCIRLI LCIL	die on e	-2	-						24a. Was a		e autopsy findings available r to completion of cause of
COr law re has b	nple										perfor		
of Vital Records, ng Physician: The law require After this certificate has been si		25. Was case referred to r	nedical				- 2	6.Place	of Death	(Check only			
Vital hysician this cert	Be	examiner?	Ho	spital: 1 Ir	npatient 2	✓ ER/Outpati	ent 3 D	OA	Other ₄	Nursing H	ome 5	Residence 6 0	Other:
of V ig Phy ig Phy ineral of	: To	27. Manner of Death		28a. Date (of Injury Day,Year)	28b. Time	of Injury 2		ry at Work		d. Describe I	now injury occurred	
on tendin sath. or: A the fu	atior	1 X Natural 5	Pending Investigation						res 2				S. J. S. A. Marchael City
Division of N pital or Attending Phy ours after division. After the	ifica	3 Suicide 6	Could not be	28e. Place	of Injury - At	home, farm, s	street, factory	office b	uilding, et	tc. 28	f. Location (S or Town, S		or Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the f	Certification:	4 Homicide	determined	(Specify)				Alman ala	to and ale	and du	e to the caus	e(s) and manner as	stated
To the Hos within 24 h To the Fur	ical	29a. Certifier 1 Certify one) 2 Medic	ring Physicia al Examiner:	n: To the bes On the basis o	t of my knowle of examination	edge, death of and/or invest	ccurred at the tigation, in my	opinion	ate and pro n, death oc	ccurred at th	e time, date	e(s) and manner as and place, and due	to the cause(s)
To the within 2 To the complet	Medical	29b. Signature and title of		and manner st	ated				e number				(Month, Day, Year)
	_	4	inh	۲ ، ک	n D			O.C.	M.E.			January 7, 20	008
		30. Name and address of	person who co	,	se of death (Ite	em 23a)							
		Ling Li, MD As	sistant Me	edical Exar	niner 11	11 Penn St	reet, Balti	more,	MD 212	201			
		31. Date filed (Month, Day	Year) 6 2	008 32. R	istrar's Sign	ature	booth	,					
Regis		JAI				ORIGI	NAI						
DHMH 17 Rev 1/2	∠∪∪1		64			ORIGI	. 4771-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Day 09 Physician 0702 A M Esther Swartzentruber C. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** WMHS Braddock Campus Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 1 F Months Days Hours Min. Director 212-38-6110 August 6,1926 PA 81 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits f show 10a. State 10b. County at la or 28a-f shot be notified a 1 ☐ Yes 2 No Director MDGarrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wir Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a c any injury or other traumatic event, the Medical Examiner must be once. 416 Hemlock Drive 21536 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify Specify: þ 3 Widowed 4 Divorced White Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olive Tice Claude E. Yoder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crist J. Swartzentruber/husband 416 Hemlock Drive, Grantsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan.12, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mountain View Cemetery Salisbury, PA 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Homes, P.A. uma 179 Miller Street, Grantsville, MD Approximate Interval Between Onset and Death 23a, Part1. Enter the lisease, or cor shock, or hear fullure. List only olications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest one cause on each line. Immediate Cause Al **Physician** disease or condition resulting in death) Arteriosclerotic heart disease Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a d be detached for P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No Be Certification: To

funeral director, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

25. Was case referred to medical			26. Place of De	ath (Check only one)
examiner? Yes 2 No	Hospital: 1 ☐ Inpatient ≥ E	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
Manner of Death Hatural 5 Pending investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	me, farm, street, fac ')	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
				e, and due to the cause(s) and manner as stated. surred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Jan 9 2008

Do9157

and manner stated

30. Name and oddress of rison who completed cause of death (Item 23a) (Type, Print)

Snow, M.D.Dpty med ex 124 W 3rd ST Cumberland MD 21502

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008

29b. Signature and title of certifier

			1 - State	State of Marylan		artment of H				2000	011	20
			Registrar 1. Decedent's Name (First, Middle, Last)	····	0		Dealit	2. Date of Dea		- 000	3. Time of De	eath
	Physici /Medio		ELIZABETH		Savage Month					Day 2008 4:		
	Examir		4a. Fecility Name (If not institution, give s	street and number)		4b. City, Town, o	Location of Death		4c. C	ounty of Death		1
			5. Social Security Number 6. Sex		laat hidhdau)	If Under 1 Year	if Under 24 Hrs.	2 Date of Birth			67567	
	Funeral Director			M 21XF	3 6 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	Y 02	J. 9. Birting	place (State or F	-oreign
	D		Usual Residence of Decedent					10000				
	show	5	10a. State 10b. County		y, Town or Lo					1	0d. Inside City	
	28a-f	rect	10e. Street and Number	(SE)	1374E	10f. Zip Code		· .	IOa Citize	n of What Cour		
	be filled within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23e or 28e-f show event, the Medical Examinar must be invitiled at	Funeral Director	238 Somas Cou)E		21	817			US.A	•	
	r deat	mer	The state of the s	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14	. Race - Americ Black, White,		
36	s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give	1	I□Yes 28No	Specify:	, , , , , , , , , , , , , , , , , , , ,	S	pecify: 131	ack	
8	2 hour	ed t	15. Decedent's Educ	Year or Dates:	16a. Deced	lent's Usual Occup	ation		16b. Kind	of Business/Inc	dustry	
215	thin 73	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done OO NOT use retired	during most of work d)	ting		0		
2	led wi lygien her th		644		1	aboreir			9	a 1000	•	
anc	d be fi	Be c	17. Father's Name (First, Middle, Last)	, AS			18. Mother's Nam	e (First, Middle,	, 1			
Σ	should ind Men s marka umatic	2	19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street	and Number or Rur	al Route Number	_	Yown, State, Zip	Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination at must be invitibled at once.		Angenelle E. Jo	n <i>ES</i>	2303	Somers a	oue Ast.	Cristie	old,	MD2	1817	
ore	Pages 1 and the proof of the pr		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Re		lace of Dispos	sition (Name of natory or other plac	ce)		4 4	ition - City or To		
III III	t. Pag rtment rtant: njury		' 4 □Donation 5 □ Other (Specify)	M	T. Year	2 Cemes	leey 01-1	2-3008		arion	MD	
Ba	permit. Departn Imports any inju		21. Signature of Funeral Service License	1121181	31		ss of Facility) <i>1</i>		21817	al Herne	5)
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death		1000		or respiratory arr		2401	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Lung	Can	con.					Opset and Dea	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):						3/	9)
	ZXdilliloi	-	Sequentially list conditions, b.	Due to (or as a consequ	ience off							
	uted d ansit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	, , , , , , , , , , , , , , , , , , , ,								
o,	e exectian an urial-tr		resulting in death) Last	Due to (or as a consequ	ence of):							
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d.									
Box 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant 23	sc. If yes, outcome of pregnar	ncy				23/	d. Date of delive	in/	
	death e atter	by Physiclan/Me	in the past 12 months?	1☐Live birth 2☐Fetal 4☐Pregnant at time of de		Ectopic pregnancy Other (specify)			200		Day Yea	ar
<u>о</u> .	at the 1 by th stache	Phys	9 🗆 Unknown	9□ Unknown					ļ			
ŝ	uires that the de signed by the a d be detached f	þ	Part II. Other significant conditions cont	tributing to death but not resu	ilting in the un	derlying cause give	en in Part I.			contribute to th		
Records,	w require	letec						24a. Was a				
	The law le has age 2	Completed						autops perforr	y ned?	24b. Were autor prior to cor death?	npletion of caus	se of
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Deat		e)	1 🗆 Yes	2 140	
<u>></u>	Physic this ce al dire	P	1 ☐ Yes 2 ☑ No		ER/Outpatient	3□ DOA Oth	er: 4 🗆 Nursing Ho)	
בט	ding P th. After i	ion:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	/ at <br Yes 2 □ No	28d. Describe ho	ow injury o	occurred		
Division of	Attendir death.	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me, farm, stre			28f. Location (St	reet and f	Number or Rura	l Route Number	Γ,
ā	tal or	Certification:	4 Homicide	building, etc. (Specify			-	City or Towr	n, State)			
	Hospi 24 hou Funer Funer tely fill	Medical	(Check only 2 Madical Examin	cien: To the best of my know er: On the basis of examinati	vledge, death ion and/or inv	occurred at the time estigation, in my of	ne, date and place, pinion, death occurr	and due to the cared at the time, d	ause(s) ar ate and pl	nd manner as st ace, and due to	ated. the cause(s)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date s	signed (Month, L	Day, Year)	
	~ s → ó) (Jarofand (SARAN R. 1	RARA	1))	5442	2	1-	8-20	08	
			30. Name and address of person who con			2 '						
			31. Date filed (Month, Day, Year)	32. Regetrar's Signate	omo	Ke, 1	40 21	851				
	Stat Registra	_		32. Heaverar's Signation	K	hand .						

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

			State of Maryland / Departr		_	_	
			- FOI	icate of Death		. No. 2000	01100
į,		19	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Dorothy C. Shanahan		Januar	'	2:10P M
)	Examin		, , , , , , , , , , , , , , , , , , , ,	. City, Town, or Location of Death		4c. County of Death	
2750		-		Denton Under 1 Year If Under 24 Hrs.	8. Date of Birth		roline
	Funeral Director			onths Days Hours Min.	(Month, Day, Y		place (State or Foreign ntry) nsylvania
	pu ,		Usual Residence of Decedent	20	- Duite 2		10d. Inside City Limits
	laryla shov	ō					1 ☐ Yes 🏋 No
	the N 28a-f	Director		Of. Zip Code	100	g. Citizen of What Cou	ntry?
	h with	Funeral Di	280 Camp Road	21629		U.S.A.	
	r deat		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Armed Forces? 13. Was If Ye	Decedent of Hispanic Origin? (Sps., specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	s afte	by Fi	1XNever Married 2 Married 3 Widowed 4 Divorced 1 New 1 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 No 11 New 2 New 2 No 11 New 2 No 11 New 2 New 2 No 11 New 2 New 2 No 11 New 2	Yes 2. No Specify:		Specify: W	nite
15-0036	be filed within 72 hours after death with the Maryland tral Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		15 Decedent's Education 16a, Decedent'	's Usua! Occupation	16	6b. Kind of Business/Ir	ndustry
212	thin 7: e. an "n Medi	Completed	(Specify only highest grade completed) (Give kind life. DO I	d of work done during most of worl NOT use retired)			-
7	filed within Hygiene. Ither than "	Con	12 Hotel 17. Father's Name (First, Middle, Last)	Management	e (First, Middle, Ma	Hotel Ind	dustry
Maryland 2	ild be fi lental F ked ot ilc ever	Be c				,	
Z Z	2 should and Men is marke aumatic	To	William J. Shanahan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Av	ddress (Street and Number or Ru	larie Co ral Route Number,	_	p Code)
	s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev		Evelyn J. Spiering/ friend 2765	0 Plummers La			
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐Removal from State 20b. Place of Disposition cemetery, cremator Chesapear	on (Name of ory or other place) Se Cr Cn 1/8		Oc. Location - City or T Chester ,	
Ē	tment of tant: If it		4 □ Donation 5 □ Other (Specify)		, 00	Jilester,	Maryrand
g	permit. Pag Department Important: I any injury o			ame and Address of Facility egle and Helf	enbein	Funeral 1	Home, PA
г	= 1=1		23a. Part1. Enter this disease, or complications that caused the death. Do not enter the shock, or hearf failure. List only one cause on each line.	Prode of dyfig, sich as cardiae	nsparares	t, MD 2163	Approximate Interval Between
	Physician			r's Demi	entia		Onset and Death
*	/Medical Examiner		resulting in death) Due to (or as a consequence of):				2
	± xammon	ē	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events .				
60,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):				
-	ate be hysici the bu	lical	d				
89 X	certific ding p	/Mec	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	ven/
ROX	death certificate e attending phys d for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1	topic pregnancy her <i>(specify)</i>		Month	Day Year
л О	at the de by the a tached	hys	9 ☐ Unknown				
	es tha gned be de	by	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.		acco use contribute to s 2 Ø No 3 □ Pro	the cause of death? bbably 4 □Unknown
Vital Records,	w requir been si should	Completed					
Ž K	ne law has t ge 2 s	mple			24a. Was an autopsy perform	ed? prior to c	topsy findings available ompletion of cause of
ā			25. Was case referred to medical	26. Place of Dea	1 Yes 2 th (Check only one		2 No
	Physicia this cer al direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	Othor		nce 6 □Other (Spec	ify)
n or	ding Pt h. After th funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	v injury occurred	
Division	Attendideath.	icati	3 Suicide 6 Could not be 28e Place of injury. At home farm street	M 1 Yes 2 No	28f Location (Stre	eet and Number or Ru	ral Route Number
2	after of Direct of in by	Certification:	4 Homicide determined building, etc. (Specify)	,,	City or Town,	State)	,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc (Check only 2 Medical Examiner: On the basis of examination and/or invest				
	To the l	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monti	n, Day, Year)
	- > F U		> = TAH MO	D 054753	4	1/8	108
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Wafik Zaki, MD 920 Market Str		MD 2162	Q	
alin'	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Cour Denicons	- L U L		
	Registr	ar	JAN 9 2008				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Pate of Death **Physician** 200% /Medical Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Security Number If Under 24 Hrs. (In yrs last birthday Date of Birth (Month, Day 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 M 2 V DU Director esidence of Decedent with the Maryland State 10c. City, Town or Location r 28a-f show notified at 10b. Cor 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director 01 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or pe Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural"; or items 23a any Injury or other traumatic event, the Medical Examiner must b death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 1 HO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Nidowed 4 Divorced Completed Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Val 17. Father's Name (First, Middle, Last) r's Name (First, Middle Be ည ant's Name/Relation (Type._®Print) 19b. Mailing Address (Street and Nun or Run Royte Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place Date Disposition 20c/Location - City or Town, State 1 Surjal 2 Cremation 3 Removal from State 5 Othe (Specify) 4 □ Da 21. Signa f/Funeral Ser hal caused the death. Do not entek the hode of dying, such as cardiac or respiratory arrest, e on each line. 23 Prin1. Enler the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) WAOCHWOITF INFARCTION Hours /Medical Due to (or as a consequence of): Examiner CORUNAY ARTENY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) CHROMIC INSUFFICIEN CY that initiated events resulting in death) Last RENAL burial-trar and Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. ate has been signed by the a page 2 should be detached it 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Unknown RHEWNATON ANTHN 1TT S 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an autopsy 2 No 1☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one, Other: 2 No P 1 ☐ Yes 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 5 ☐ Pending investigation 1 Natural (Month, Day Year) Injury 1 □ Yes 2 □ No M 2 Accident completely filled in by the 3∏ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00047711 ハり 4,2008 JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite =3 304-306 ELLTON North Street MARTLAND 31. Date filed (Month, Day, 32. Registrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760,

Maryland 21215-0036

Bai

DHMH 17 Rev 1/2001

State

Registrar

LUDWIG J

EGLSEDER.

III

2008

M.D. Registrar's Signative

219 SOUTH WASHINGTON STREET, EASTON, MARYLAND 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Vear **Physician** 1123 C M 24-/Medical 5700 2048 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9 Brthplace (State or Foreign Country) 5. Social Security Number Hor If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min. 1 □ M 2 🕱 F Director 062-05-1634 92 24, 1915 NEW YORK JUNE Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND MONTGOMERY TXTYes 2 TNo Director SILVER SPRING 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 15100 INTERLACHEN DRIVE #823 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify WHITE Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT 12 US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PHILIP GOLDSTEIN ROSE KLUGMAN ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET HUNGERFORD, DAUGHTER 739 SANTA RAY AVENUE, OAKLAND, CA 94610 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 TxBurial 2 □ Cremation 3 □ Bemoval from State MT. LEBANON CEMETERY 01/06/2008 4 ☐ Donation 5 ☐ Other (Specify) ADELPHI, MARYLAND 21. Signatur 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, Force Service Licensee divin 1091 ROCKVILLE PIKE, ROCKVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** antes /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 ☐ No Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4- Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1. Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Funeral I 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hour To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 7 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20057884

an

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrer	State of Ma	-	partmen ertificate			ind M		iene .g. N2 ()	08		36
	Physici		1. Decedent's Name (First, Middle, Last Larr		naffer					2. Date of Deat Month Januar	Day	Yeer 2008	3. Time o	of Death
	/Medio Examir		4a. Facility Name (If not institution, give Julia Manor Heal		enter			Location o			4c. Cou	nty of Death		11.
	Funeral Director		5. Social Security Number 6. Se 169–38–5620		o (In yrs. last birthd 56 Yrs	ay) If Under Months		If Under 2 Hours		8. Date of Birth (Month, Day, Oct. 24	Year)	9. Birth	place (State	or Foreign
	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-1 show the Madical Examiner must be notified at	rai Director	Usual Residence of Decedent 10a. State 10b. County Penna. Frankli 10e. Street and Number 164 North Allison	St.		castle 10f. Zip	1722				U.S	of What Cou	ntry?	City Limits s 2 ☐ No
15-0036	in 72 hours after de n "naturel", or Item Ladical Examiner	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed. (Specify only highest grad	12. Was Decedent E Armed Forces? 1 Tyes 2 No. 1 1/4 Yes, Give Year or Dates:	16a. De	3. Was Deced If Yes, spec 1 ☐ Yes : cedent's Usua ive kind of wor a. DO NOT us	No No	Specify: ation		cify Yes or No- Rican, etc.)	Spe	Race - Ameri Black, White, acify: Wh Business/Ir	etc. ite	
Maryland 21215-0036	be filed ntal Hygi od other event, I	Be	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) G. William	College (1-4or 5	1)	undry V		18. Mother		(First, Middle, M	Maiden Sun	•		
	d 2 shouth and M	7	19a. Informant's Name/Relationship (T) Bonita L. Shaffer	rpe, Print)				and Numbe	r or Rurai	Route Number	City or To	wn, State, Zij		
Baltimore,	of of		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)		20b. Place of Discometery, of Geisel And Cre	Funeral matory matory	her plac Hot	ne	1/11	ate L/08		ersbu		١.
Bal	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens H. Mattur 2	nema-			an Zarl	And So isle S	on Fu St. (neral F Freencas		nc. Pa. 1	7225 Approxima	ata
8,0928	death certificate be executed Wedgical e attending physician and for use as the burial-transit	dical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due	a consequence of):	An structurales	function !	jose In	lma	vary	03	erse	Interval Be Onset and	Death
P.O. Box 6	death certif e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pro					23d.	Date of deliv Month	ery Day	Year
	sign sign d be	by	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	e underlying ca	ause give	en in Part I.			oacco use c es 2 □ No	ontribute to t	the cause of bably 4	
al Recc	The law ate has b page 2 s	Completed									y ned? MNo	b. Were auto prior to co death? 1 \(\sum \text{Yes}	fo noiteland	available cause of
Division of Vital Records,	ing Phys After this uneral dii	ation; To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 1 Accident investigation	lospital: 1 Inpatier 28a. Date of Injury (Month, Day	nt 2 ER/Outpa y Year) 28b. Time Injur		Bc. Injury Work	er: 4 A Nur	sing Hom 2	(Check only on the 5 Reside 8d. Describe ho	nce 6 □		fy)	
Divis	ital or Attendirs after death al Director: A ed in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At home, farm, (Specify)	street, factory	, office		2	8f. Location (St. City or Town		ımber or Rur	al Route Nur	mber,
	he Hospital of the Function of the Function of the Function of the function of	edicai	(Check only 2 Medical Exami	sicien: To the best oner: On the basis of and manner state	examination and/or	eath occurred a investigation,	at the tim in my op	e, date and pinion, deat	d place, a h occurre	d at the time, da	ate and plac	e, and due t	o the cause((s)
)	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier				03				0/-	ned (Month,		
	10		30. Name and address of person who co	-		11	HAL 26	ED M OPAL	1. W	ASEEM HAG	I, MO. ERST	OWN	Ma 2	-1740
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 2 2 200	8 32 Registra	r's Signature	only								

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month)

egistrar's Signature

Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral D completely filled i

January 18th, 2008 D-61614 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11350 PEMBROOK SQ , SUITE 304 , RAVINDER SINDHWAN I M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL**

R. Sindheum

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i> a	artment of H <i>rtificate of l</i>			iene () () () ()	01439
	Dhusis		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death	1	3. Time of Death
	Physic /Medi		Mabel Tobery					1/14/	Day Year / 2 0 0 8	8:10 A M
	Examir		4a. Facility Name (If not institution, gire	e street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ath
		Ш	College View (Freder		,	Freder	
	Funeral			Sex 7. Ag 1 □ M 2 🖾 F	e (In yrs. last birthday) O O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
	Director		216-62-2907 Usual Residence of Decedent		9 9 Yrs.			6/7/19	0.8	MD
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mar B-1	tor	MD Frede	erick	Frede	rick				1 ½ Yes 2 ☐ No
	ith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	country?
	ath w	le l	2477 Five Shil	lings Ro	ad	21701			USA	
	er de	nue	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
36	within 72 hours after death with the Maryland ene. then "natural", or iteme 23a or 28a-f ehow ita Medical Examiner must be routified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 ! If Yes, Give Year or Dates:		1 ☐ Yes 2√ No	Specify:		Specify:	
ğ	2 hou	led	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Business	hite Madustry
215	thin 7 9.	Completed	(Specify only highest grid Elementary/Secondary (0-12)	ade completed) College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of work)	ng		
2	od wil	Con	7			omemaker			Own Hom	e
<u>n</u>	be fill d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Sumame)	
$\frac{2}{5}$	ouid I Men narke	မ	William Allen				Lilli			
Maryland 21215-0036	d 2 st th and 7 ts n traun	11	19a. Informant's Name/Relationship (City or Town, State,	
ē,	1 an Heal tem 2	l i	Mary V. Dove 20a. Method of Disposition	Granddau	ght. 2477 20b. Place of Dispo	sition (Name of			ederick Oc. Location - City o	
آ ا	ages ant of nt: ff i		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia	Removal from State	cemetery, cren	natory or other place	.			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Evertiner must be notified at ODGe.		21. Signature of Funeral Service Lice	•		mel Cem	s of Facility IZ	/2008 F	rederic	P.A.F.H.
m	a a a a		Toh Che	nano	M01176 1	06 East	Church	eney & St Fr	ederick	P.A.F.H. MD 21701
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only		the death. Do not ent	er the mode of dying	g, such as cardiac o	or respiratory arres	st,	Approximate Interval Between
Z	Physician		Immediate Cause (Final disease or condition	Co		(c) co 0				Onset and Death
	/Medical Examiner		resulting in death)	a Due to (or as	a consequence of);	100				2 cun j
	Cxammer	L	Sequentially list conditions,	b						
0	ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
128	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	The law requires that the death certificate be executed tie has been signed by the attending physicien and bege 2 should be detached for use as the burial-transit			d						
-	tificat ng phy as th	fedical		V						
Box	leath certifi attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth		Ectopic pregnancy			23d. Date of de	livery
0	e dea the at ned fo	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown		Other (specify)			Month	Day Year
٦.	hat th	F.	Part II. Other significant conditions of	ontributing to death by	ut not requiting in the unit		- 1- 0 1	CO. Didust		
g,	uires that the dei signed by the a Id be detached f	d by	Hypu	rtu si		idenying cause give	nın Panı.	1 ☐ Yes		o the cause of death?
Ö	w requir been si should	ete	110						1	
ě	The lav	Completed				<u> </u>		24a. Was an autopsy performe	24b. Were a prior to death?	utopsy findings available completion of cause of
Vital Records,		0	25. Was case referred to medical	1)		-	OS Olean of Doort	1□ Yes 24	No 1 ☐ Yes	2 □ No
$\bar{\leq}$		ToB	examiner?	Hospital: 1 ☐ Inpatie	nt 2□ER/Outpatient	3 DOA Othe	26. Place of Death		ce 6 □Other (Spe	acciful.
ס ר	ng Ph ter th neral		27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	y 28b. Time of	28c. Injury Work	at 2	28d. Describe how		City)
<u> </u>	endir eath. or: Af he fu	atlo	2 ☐ Accident investigation	1	injury		es 2 □No			
DIVISION	al or Attending F s efter death. il Director: After id in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	iry - At home, farm, stre . (Specify)	et, factory, office	4	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
_	pital		COO Contilled A Provide a Ph							
	To the Hospital or Attending Phys within 24 hours either death. To the Funeral Director: Aller this completely filled in by the funeral di	edical	29a. Certifier 4 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best on niner: On the basis of and manner sta	of my knowledge, death examination and/or inv	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	and due to the cau ad at the time, dat	ise(s) and manner a e and place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		100.	29c. License	number	290	d. Date signed (Mont	h, Day, Year)
) Cari	tin lo	arval	Da	9/ 60	1	1/15/1	9
	21	}	30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, f	Print)	100		.(12)	0
	X		Dr. A. Austin		Jr. MD 30	00 W 9th	St. Fr	ederick	, MD 21	701
	Sta	_	31. Date filed (Month, Day, Year) 201	32 Registra	r's Signature	all s				
	Registra	1	AND R. R. A.	est -	200					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

larguerite Thorn		1- For State Certificate of Death			. No. 2008	
Physicia	n/	1. Decedent's Name (First, Middle, Last) Marguerite B. Thornton	L I	Date of Death	Day Year	Time of Death 0255 hrs
***		4a. Facility Name (if not institution, give street and number) 4b. City, Town, o	r Location of Death	January 2, 4	4c. County of Death Anne Arundel	
Funeral		Anne Arundel Medical Center Annapolis 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye			(MM/DD/YYYY) 9. Birthp	
Director		218-68-3383 1 Months Day	ys Hours Min.	Aug.2	,1959 West	ington, DC
Maryland 28a-f show any d at once	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel 10c. City, Town or Location Dunkirk 10c. Street and Number 10f. Zip Code		1100		Od. Inside City Limits Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once	Director	140 Chickadee Drive 20754		100	United Stat	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mertal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matie event, the Medisal Examiner must be notified at once	by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup:	n, Mexican, Puerto Rio	can, etc.)	14. Race - America White, etc. Specify: Whit	e
6 n 72 hou an "nat ical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker			own home	
Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical	Be	17. Father's Name (First, Middle, Last) William Boyle	18.Mother's Name (F	ig	aiden Surname)	
MD 21 d 2 should tth and Me n 27 is ma rumatic ev	٩	19a. Informant's Name/Relationship (Type, Print) Thomas L. Thornton -husband 19b. Mailing Address (Street 140 Chickade)	et and Number or Rur e Drive Du	nkirk,	ber, City or Town, State, 2 Maryland 20	(ip Code) 1754
ore, Nest and of Health If item		20a Method of Disposition 20b. Place of Disposition (Name of c crematory or other place)		Date /2009	20c. Location - City or To	· ·
Baltimore, permit. Pages 1 an Department of He Important: If ite		21 Signature of Funeral Service ticensee 22 Name and Address 23 Name and Address 24 Donation 5 Other Specify: 25 Name and Address 26 Name and Address 27 Name and Address 28 Name and Address 29 Name and Address 20 Name and Address 20 Name and Address 20 Name and Address 20 Name and Address 20 Name and Address 21 Name and Address 22 Name and Address 23 Name and Address 24 Name and Address 25 Name and Address 26 Name and Address 27 Name and Address 27 Name and Address 28 Name and Address 27 Name and Address 28 Name and Address 27 Name and Address 28 Name and Address 27 Name and Address 28 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Address 27 Name and Name a	1		Silver Spri al Home, PA tsville, <u>Mar</u>	<u> </u>
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying failure. List only one cause on each line.	g, such as cardiac or re	espiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a Pulmonary Thromboembolism Due to (or as a consequence of):				Death ———
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
Red ansit	Examine	cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		=		
), be executed sician and urial - transit	dical	UNPENDED AMENDED		-		
Division of Vital Records, P.O. Box 68760, To the Itospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the but	sicial	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Ectopic pregnanc	су	23d. Date of delivery Month Da	y Year
, P.O. Boires that the de signed by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		bacco use contribute to the	
Division of Vital Records, F tal or Attending Physician: The law requires rs after death. 31 Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed			24a. Was a autops perform	an 24b. Were auto sy prior to co med? death?	psy findings available mpletion of cause of
tal Reco	Be Co	examiner?	ce of Death (Check on			<u> </u>
on of Vit nding Physic th. :: After this e funeral din	P	1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month. Day, Year) 28b. Time of Injury 28c. In			Residence 6 Other:	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office (Specify)	e building, etc. 2	8f. Location (S or Town, St	Street and Number or Rura tate)	al Route Number, City
To the Hosp within 24 ho To the Fun completely f	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, which will be the death occurred at the time, one) Medical Examiner:On the basis of examination and/or investigation, in my opini	date and place, and do	ue to the cause the time, date a	e(s) and manner as stated and place, and due to the	d. cause(s)
Vitto Tour	Mec	and manner stated. 29b. Signature and title of certifier 29c. Lice	nse number		29d. Date signed (Mont	
		30. Name and address of person who completed cause of death (Item 23a)	C.M.E.		January 2, 2008	
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Bal	timore, MD 2120	1		
St. Regist						

DHMH 17 Rev 1/2001

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Mervin Victor Towers 8:00 P M 2008 January 6, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 10801 Greensboro Road Denton Caroline if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2 F 78 September 12,1929 Maryland Director *221 - 20 - 0 2 2 1* Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes Æ☐ No Director Caroline Maryland Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 10801 Greensboro Road United States of America Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2ĂNo Specify: Caucasian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 HS Grad. Parts Manager Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarence Thomas Towers Victoria Lee Betts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis A. Towers Wife 10801 Greensboro Road, Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Denton Cemetery 1/10/2008 Denton, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, a conshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final LUNG CARCINDMA, non-small cell **Physician** 2 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed as the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 3 Probably 4 □Unknown 1 Tyes 2 🗌 No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1□ Yes 2 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Nesidence 6 ☐ Other (Specify)
Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Seath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

Division or Vital Records, P.O. Box 68760. within 24 hours a

29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2008

RUALO, M LN. DENTON, MD 21629 DAFFIN 609

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		C	ertificate of	Death	R	eg. No. ე ე ე (2 011.1.2
	Dhuniai		1. Decedent's Name (First, Middle	, Last)				Date of Deat Month	h & UU (Day Yea	3_Time of Death 4_
	Physici /Medic		HAROLD	WENDELI		THOMPS	SON	JANUARY		
	Examin	er	4a. Facility Name (If not institution)		r Location of Death		4c. County of De	
	The same of the sa		13795 PETZOL		ge (In yrs. last birthd	WALDOI av) If Under 1 Year		8. Date of Birth	CHARL	E.S sirthplace (State or Foreign
	Funeral Director		5. Social Security Number 227-48-9637 Usual Residence of Decedent	1 M 2 F	67 Yrs	Months Davs	Hours Min.	(Month, Day,	Year) (ASHINGTON, D
	land w t		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	Mary f sho	ţō	MD CHAR	LES	WALDOR	ਜ ਼				1 □Yes 2 No
	r 28a	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?
	h with	밀	13795 PETZOL	D DRIVE		20601	l		U. S	. A.
	ems er mu	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	I IT YES, GIVE	₹No	1 ☐ Yes 2 ☑ No			Specify: W	HITE
2-0	72 ho 'natu	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	1 (6	ecedent's Usual Occu live kind of work done	during most of wor	king	16b. Kind of Busines	:s/Industry
2	ithin ne. e Mec	du.	Elementary/Secondary (0-12)	College (1-4or	5+)	e. DO NOT use retire	,		an a annu	aman n
2	led w lygier her th	ខ	12 17. Father's Name (<i>First, Middle,</i>	Last)	ST	OCK_CLERI		ne (First, Middle, i	GROCERY Maiden Surname)	STORE
and	ntal Hed ot	Be	STACEY LEON				1		ETH JENK	TNS
ž	hould d Me mark matic	ျှ	19a. Informant's Name/Relations		19b. M	ailing Address (Street				
Maryland	id 2 s ith an 17 is i		ELIZABETH TH			795 PETZ(
ē,	Heal Heal tem 2	- 3	20a. Method of Disposition		20b. Place of D	sposition (Name of crematory or other pla		Date IUARY	20c. Location - City	
Baltimore,	ment of tant; If i		1 ☐ Burial 2d 3d Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	METRO	POLITAN	CR. 5. 2	2008	ALEXANDR	
Ball	permit Depart Import any In		21. Signature of Euneral Service	Licensee	0479					VICE, P.A. MD 20646
	- 400		23a. Part1. Enter the disease, o shock, or heart failure. List	complication that cause	ed the death. Do not					Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	For	THICF	R				Onset and Death
a	/Medical		resulting in death)	Due to (or a	is a consequence of)					
ľ	Examiner		Sequentially list conditions	b. D1	ABETES					
٣	P #	iner	Sequentially list conditions, if any country of the cause. Enter Underlying Cause (Disease or injury	Due to or a	is a conse juence of)	II - ADT	FAILU	OF		3
120	ecute and trans	Examine	that initiated events resulting in death) Last			HEART				
60,	be ex		,,	Co	RONADY	AFTERY	DISFAC	F		
68760,	icate be executed physician and s the burial-transit	Medical		d	14 0 14/1 K /	1171243	D17 E/1 V			
Box 6	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne pf pregnancy 2 Fetal death	3□Ectopic pregnanc	27		23d. Date of	*
O. B	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		at time of death	5 ☐ Other (specify)			Month	Day Year
Δ.	uires that the de signed by the a Id be detached f		Part II. Other significant conditi	ons contributing to death	but not resulting in th	ne underlying cause gi	ven in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
rds,	quires n sign ald be	d by	HYPERT	ENSION				1 □ Y	'es 2 No 3 □	Probably 4 Unknown
Records,	law requir as been s 2 should	Completed	PULMO	NARY HYPE	MENSION	J		24a. Was a	an 24b. Were prior	autopsy findings available to completion of cause of
H	The ate h page	Ş	PERIF	HERAL HEA	ART DIFEA	SE			med? death	1?
/ita	sician: Th certificate rector, pag	Be (25. Was case referred to medica examiner?					ath (Check only o	ne)	
7	di Si	은	1 Yes 2 No		tient 2 ER/Outp	attent 3[] DOA	her: 4 Nursing F	-	ence 6 Other (S	ipecify)
n c	ding Phy n. After thi funeral c	in o	27. Man r of Death 1 atural 5 □ Pendi	19	njury 28b. Tin Day Year) Inju	ıry Wo	ork? ☐Yes 2☐No	28d. Describe n	ow injury occurred	
Sic	e at a	cati	3 Suicide 6 Could		100	, street, factory, office		28f Location /9	Street and Number of	r Rural Route Number,
Division or Vital	or Attendate death	Certification:	4 ☐ Homicide deterr	building,	etc. (Specify)	, direct, factory, office	, 	City or Tow	n, State)	, 14,4,7,10010
-	spital ours neral filled		29a. Certifier 1 Certifyi	ng Physician: To the be	st of my knowledge,	death occurred at the	time, date and plac	e, and due to the	cause(s) and manne	r as stated.
	e Ho 24 h e Fur letely	Medical	(Check only 2 ☐ Medica one)	Examiner: On the basis and manner:		or investigation, in my	opinion, death occ	urred at the time,	date and place, and	due to the cause(s)
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Me	29b. Signature and title of certific	ər		29c. Licen	ise number		29d. Date signed (M	~
) (X)	MU ND		DO	057518	}	1/4/08	3
7	10		30. Name and address of persor	12 8	f death (Item 23a) (Ty				MARYIA	NT
		ate	31. Date filed (Month. Dav. Year				1	/11550 /	- 11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	142
	St Regist		31. Date filed (Month, Day, Year JAN 2	2 2008	Visit See of	foots.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 2008 07:56 PM **JANUARY** GEORGE ALVIN USILTON 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **QUEEN ANNE** CENTREVILLE 304 QUEEN ANNE CIRCLE DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**▼** M 2□ F Months Davs Hours 63 219-42-8632 FEB. 22, 1944 MARYLAND Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 XNo **QUEEN ANNE** CENTREVILLE Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or adical Examiner must be r 21617 USA 304 QUEEN ANNE CIRCLE DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: \$ WHITE 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i Hygiene. Elementary/Secondary (0-12) 10 College (1-4or 5+) HANDYMAN HOME IMPROVEMENT **_**∩_ of Health and Mental Hygie If Item 27 Is marked other to or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be MARY HELEN MOORE CARROLL USILTON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1744 HOPE ROAD, CENTREVILLE, MD 21617 of Health MARGARET R. CHANCE/ SISTER Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION ± 5 STEVENSVILLE, MD permit. Page Department of Important: If any injury or 1-9-2008 4 □ Donation 5 □ Other (Specify) CENTER 21. Signature of Fune al Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arteres **Physician** (nonary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sequence of) Examiner The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atten 3 ☐ Ectopic pregnancy ō Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached Division or Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 potrykopism 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy page perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours atter death.

neral Director: A
filled in by the fu death. 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only within 24 and manner stated. 29b. Signature and title of certifie Dhysician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mentle ROAD, Centreville, Gobdman D.0 Vale ell egistrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

		For State Registrar		State of IV	iaryian			inent of r			-	greni Reg. No	000	ΠΩ	01	1. 1. 1.
	1	Decedent's Nam	ne (First, Middle, L	Last)		-				2	. Date of De	ath	-	<u></u>	3. Time	of Death
Physicia /Medic	an al	May.	rice	Alphous!		/er	ley	sen			Month	Da	2	Year 2008	9;	SUM
Examin	er	1/	(A)				0 4	b. City, Town, o	/	,		40	c. County	of Death	0	
		Howard		1 Gener		Hosp	et.)) west				HU	200-		
Funeral Director		5. Social Security N 200-60-3 Usual Residence of	256	Sex 7. A 1 <u>X</u> M 2 □ F	ge (In yrs.			If Under 1 Year Months Days	If Under Hours	Min.	Date of Bir (Month, Da an 7,	th ly, Year 192	6	9. Birthp Cour Japa		or Foreign
land sw		10a. State	10b. County		10c. City	y, Town	or Locat	tion						1	10d. Inside (City Limits
Mary -f sho ied a	ğ	MD	Howard		E114	icott	- 01	+							1 □Ye	s 2 XNo
r 28a	Director	10e. Street and Nu			<u> [</u>	LCOLI		10f. Zip Code				10g. C	itizen of W	Vhat Cou⊦	ntry?	
th with	a D	3713 Mac	alpine R	load				21042				USA				
ems er mu	Funeral	11. Marital Status	•	12. Was Deceden Armed Forces	Ever in U.	.S.	13. Wa	s Decedent of F es, specify Cub	Hispanic Or an, Mexica	igin? (Speci	fy Yes or No)-		e - Americ k, White,	can Indian, etc.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Mari 3 ☐ Widowed	ried 2 ∑ Married 4 ☐ Divorced					lYes 2⊠ No			,		Specify:			
72 h 'natu dical	etec	(Spe	15. Decedent's ecify only highest of			1 6	Give kin	nt's Usual Occup nd of work done	during mos	st of working		16b. l	Kind of Bu	siness/In	dustry	
vithin sne. than '	Completed	Elementary/Seco	ondary (0-12)	College (1-4or	5+)			NOT use retire	•		3.6					
filed v Hygie ther t	ပ္ပိ	17. Father's Name	(First. Middle, La	4st)		Inte	erna	tional	_	lt10ns er's Name <i>(l</i>					10	
d be a	o Be		•	Verleysen					1	nelita				,		
shoul nd Me mark	ဍ	19a. Informant's N				19b. l	Mailing /	Address (Street							Code)	
nd 2 alth a 27 Is r trat		Francois	R. Verl	eysen/son		371	13 M	lacalpin	e Roa	d Ell:	icott	Cit	у, М	210)42	
is 1 a of Hez		20a. Method of Dis		_		Place of E	Dispositi	on (Name of tory or other pla	ce)	Dat	е	20c. L	_ocation -	City or To	own, State	
Pages nent of l int: If its		1 ∐ Burial 2 4 ☐ Donation	Cremation 3 5 ☐ Other (Special	☐Removal from State cify)	3			Cremat	- ' i	1/5/0	8	Bel	tsvil	lle,	MD	
permit. Departn Importa any Inju	Ì	21. Signature of F	uneral Service Lic	ensee /			22. N	lame and Addre	ess of Facil	itv						
Depart Impo		Deu	ells L.	Health	MO 1	251	Bev	erly L.	Heck	rotte	. P.A.	C1				21029
		23a. Part1. Enter	the disease, or co art failure. List on	implications that cause ly one cause on each	d the deat	h. Do no	t enter t	the mode of dyi	ng, such as	s cardiac or i	espiratory a	rrest,			Approxima Interval B	ate etween
Physician		Immediate Cause disease or condition	(Final	11	uno										Onset and	1-Death
/Medical Examiner		resulting in death)	4	Due to (or a		-):									J
LAMITIME		Sequentially list co	onditions,	b												
be tis	Examiner	Sequentially list co if any, leading to ir cause. Enter Unde	mmediate erlying	Due to (or a	s a conseq	uence or):									
be executed sician and burial-transit	xan	cause (Disease or that initiated event resulting in death)	s Last	c Due to (or a	s a conseq	uence of):							-+		
tificate be executed ig physician and as the burial-transit																
tificate ig physi as the I	edical			d							-					
leath cert attending I for use a		IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcom	e pf pregna	ancy	۰۵۵						23d. Date	e of delive	ery	
The law requires that the death cer Ite has been signed by the attendir bage 2 should be detached for use	Physician/N	in the past 12	2 months?	1 □Live birth 4 □ Pregnant 9 □ Unknown				ctopic pregnanc other <i>(specify)</i> _	У				Mor	nth	Day	Year
at the de by the	hys	9 ☐ Unknowr	n	9LI Unknown												
es tha	by F	Part II. Other signi	ificant conditions	s contributing to death	but not res	ulting in t	he unde	erlying cause giv	en in Part	l.				/	he cause of	
w requires that been signed to should be deta	Completed by	Scy0515,	3400	k, Pane	7 togo	78001	· G				10	Yes 2	2 No	3 ⊡*Prob	bably 4]Unknown
has be	ple	Type II	Dobeh	5 mol	(F).	5	0	per G	CB	see	24a. Was auto	psv	D	orior to co	opsy finding impletion of	s available cause of
	00	LIVE	179	55			/	,			perfo	ormed? 2 ☐ N	_ d	death?	2 □ No	
sician: Th certificate rector, pag	Be	25. Was case refe examiner?		Hannital				100		e of Death (Check only o	one)				
shys this al dii	2	1 Yes 2 2	_	Hospital: 1 Inpat				OLI DOX		ursing Home					fy)	
Jing 1 After funer	ö	1 Natural	5 ☐ Pending investigati	(Month, D	ay Year)	28b. Tir Inj	ury	28c. Inju Wo M 1	ryat rk? Yes 2. □	1	d. Describe	now inju	ury occurr	ea		
death death ctor: y the	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not	be 280 Place of it	iury - At ho	ome, farn	n, street		163 2		f. Location (Street a	and Numbe	er or Run	al Boute No	ımber.
after after Dire	erti	4 ☐ Homicide	determine	building, e	itc. (Specif	y) '					City or To	wn, Sta	te)		AI 1 1 0 0 1 0 1 1 0	
Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director,	alc	29a. Certifier	1 ertifying	Physician: To the bes	t of my kno	wledge,	death o	ccurred at the ti	me, date a	nd place, an	d due to the	cause(s) and ma	unner as s	stated.	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification:	(Check only one)	2∐ Medical Ex	aminer: On the basis and manners	of examina tated.	ition and/	or inves	stigation, in my	opinion, de	ath occurred	at the time,	date a	nd place, a	and due t	o the cause	(s)
To the within 2 To the complet	Ž	29b. Signature and	d title of certifier	1				29c. Licens	se number			29d. D	ate signed	1 (Month,	Day, Year)	
		1	2/4	La	7	no	9	04	612	20		50	on	3	200	8
2)2		30. Name and add	lress of person wh	o completed cause of	death (Iten	n 23a) (T	ype, Pri	int)	. 1			,	/			
			on 1	0724	1/1/2	/	atox	rent	VIca	7	Ci	lun	5.0		NO	21044
Sta Registr		31. Date filed (Mor	IAN O R	2008 32. Hagis	rar's Signa	lture M2	A.	2000		1						
Registr	al		JAN U O	LUUU NOO	400.	15	As a second	MU								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per verb., 8875.01/23/08dbb

Certificate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:44 PM January 1 > 2-1 Micheal A. Wilsey /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Memorial Hospital Harford Havre de Grace If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth Month Day, Year 1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**№** M 2□ F Days New York 062-12-9022 86 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Maryland Harkord Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 3132 Aldino Road 21028 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Steel Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be f and Mental h is marked of Durwood Wilsey Estelle Walsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael D. Wilsey P.O. Box 143 Atglen, PA 19310 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ite
any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) Philadelphia Mem. Park 1/18.2008 Frazer, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wilde Funeral Home 434 Main Street, Parkesburg, PA 19365 23a. Part1. Enter the disease, or mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner 03+ Obstanctive Sequentially list penditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed DON SMALL years CR Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? brain retain 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2√2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 26X No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

29b. Signature and title of certifier

free

31. Date filed (Month, Day, Year)

30. Name an Ide

o pleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

hompson

29c. License number

Harre

Dog 53568

501 South Union Avenue

29d. Date signed (Month, Day, Year)

January 14.

Grace, Maryland 21078

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Walter Howard Wensel, Sr January 3:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 6 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours **1924** 1 X M 2 □ F 83 MD 216-18-1910 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 602 Geneva Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes Ž No þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Gasoline Tax Division State of MD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Bertha Nicholson Floyd Wensel, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Wensel, Jr/son 941 Keller Drive Red Lion, PA 17356 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Purial 2 □ Cremation 3 □ Removal from State Oakland Cemetery 1/05/2008 4 ☐ Donation 5 ☐ Other (Specify) Oakland, MD 21. Signature of Funeral 8 Prices Admeration Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rear failure. List only one cause on each line. Enter the Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any reading to immodule cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit certificate be executed Due to (or (s a onsequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 □Unknown 1 ☐ Yes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has Division or Vital Yes Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3□ DOA 은 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Injury 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ar completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, beath occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examines. On the bast of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29a. Certifier Medical (Check only 2 Medical Examiner vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ~Pr 24

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) \(\) \(

		1 - For State Registrar 1. Decedent's Name (First, Middle, L.			•	tificate of L			Reg. No. 2	08	3. Time of Death
Physici		NATHANIEL	asij	W	OOD			Month JANUAR	Day	Year 008	2:30 P ^M
/Medic		4a. Facility Name (If not institution, g	ive street and number		OOD	4b. City, Town, or	Location of Death	1	4c. County		2.30 1
		3910 92nd AVENU	JE			SPRING	DALE		PRINC	CE GEO	ORGE'S
Funeral Director	DHE.	214-28-9604	Sex 7. A		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da OCT • 1	ay, Year)	9. Birthp Coun MA	lace <i>(Stat</i> e or Foreign try) RYLAND
3		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				11	0d. Inside City Limits
f sho	ō		E GEORGE'S	1 '	SPRING						1 XYes 2 No
28a- notif	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?
3a o	a D	3910 92nd AVENU	JE			20774			US	SA	
er mu	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.	S. 13. \	Nas Decedent of His f Yes, specify Cuba	spanic Origin? (Sp	pecify Yes or No	0- 14. Rac	ce - Americ	
Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	1 TYes 2 If Yes, Give Year or Dates	''' Arm	100	1 ☐ Yes 2 ☐XNo	Specify:	o moun, oto.y	Specif	73.7	LACK
"natu dical	etec	15. Decedent's l (Specify only highest g	Education trade completed)		(Give	lent's Usual Occupa kind of work done d	urina most of wor.	king	16b. Kind of B	usiness/Ind	lustry
than he M	Completed	Elementary/Secondary (0-12) 10th	College (1-4o	5+)		DO NOT use retired, FODIAN				GOVERI	MENT
Hygi other ent, t	Be C	17. Father's Name (First, Middle, Las	s <i>t</i>)		005		18. Mother's Nam	ne (First, Middle		_	VIIIIVI
Menta arked artic ev	To B	ODEN WOOD					IRENE		BROOKS		
alth and 27 is ma er trauma		19a. Informant's Name/Relationship SHIRLEY WOOD/V				ng Address <i>(Str</i> ee <i>t a</i> 92nd AVEN					
of He fitem rothe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	□Removal from Stat		Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location	City or To	wn, State
tment tant: I jury o		4 □ Donation 5 □ Other (Spec		MD		ANS CEMET		1/2008	CHELTEN	NHAM,	MARYLAND
Depart Import any In once,		21. Signature of Funeral Service Lic	ensee UCCM	al		Name and Addres AAAA LAND	J		NKINS FU VER, MAI		
ysician Medical taminer	-0	23a. Part1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. ACUT	E HEPA s a consequ STATS	ATIS ENuence of):	er the mode of dying NCEPHALOPA CREATIC CA	ATHY	or respiratory a	arrest,		Approximate Interval Between Onset and Death
g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequ	uence of):						
been signed by the attending should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)				ite of delive	ery Day Year
ned b	by Pł	Part II. Other significant conditions DIABETES MELLI		but not resu	ulting in the ur	nderlying cause give	n in Part I.	23e. Did	tobacco use con	tribute to th	ne cause of death?
en sig ould b		——————————————————————————————————————	.105					1 🗆	Yes 2□ No	3 Prob	ably 4 XUnknown
as be	Completed	HYPERTENSION						24a. Was	an 24b.	Were auto	psy findings available
page	Con	PULMONARY EMBO	LISM					perf 1□ Yes	ormed?	death? 1 □ Yes	2 √ No
sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Otho	26. Place of Dea	th (Check only	one)		
this and in	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpa 28a. Date of In		ER/Outpatien 28b. Time of		4 LI Nursing H		idence 6 Ott		/)
within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should by	cation	1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not	(Month, E	ay Year)	Injury	M 1 □ Y	? /es 2□No		how injury occur		
rs after d al Direct led in by	Certification	4 ☐ Homicide determine	d Zoe. Place of I	njury - At ho etc. <i>(Specif</i>)		eet, factory, office		28f. Location (City or To	(Street and Numi wn, State)	ber or Rura	I Route Number,
n 24 hou ne Funei pletely fil	Medical	29a. Certifier 1 ☑ Certifying F (Check only one) 2 ☐ Medical Example 1	Physician: To the bes aminer: On the basis and manner:	of examina	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	e, and due to the urred at the time	e cause(s) and m	anner as st and due to	ated. the cause(s)
With Som	Ž	29b. Signature and title of certifier	00	,	10	29c. License	number		29d. Date signe	d (Month,	Day, Year)
79		/	W Drul	ags n	THE STATE OF THE S	D247	20		JAN	UARY	4, 2008
12/		30. Name and address of person who									
Sta	40	RAVINDER K. R 31. Date filed (Month, Day, Year)		trar's Signa		OVER ROAD	CHEVERI	LY, MARY	LAND 20	785	

DHMH 17 Rev 1/2001

State

Registrar

JAN 0 7 2008

08-00088 Clarence Wayne	e Wi		or Print in Black Ir e of Maryland / Depa				ble. 2008 0	1 1 1
		1- For State Registrar		rtificate of l		Reg.	No.	
Physici	an/	1. Decedent's Name (First, Middle,Li	WAYNE U	()/5	2 : 11	Date of Death Month	3. Time of De	
Medical Exami	ner	CLAREXICE 4a. Facility Name (if not institution, g			City, Town, or Location of Dea	January 4, 2	0008 0325 hr	S
		3600 Dudley Avenue	give street and number)	1	Baltimore	ui	To. County of Death	
Funeral Director		4	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If Under 24H Months Days Hours M	/	MM/DD/YYYY) 9. Birthplace (State Foreign Country)	
		Usual Residence of Decedent	∆W 2_F '7J			/ / / /		
» any		10a. State 10b. County		Town or Location			10d. Inside (
land -f shov	ţō	MD		SAltimo			1 X Yes	2No
ith the Maryland 23a or 28a-f show notified at once.	Director	3600 Dudli	EY AVE		10f. Zip Code 21213	109	Citizen of What Country?	
r death w	Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No lf Yes, Give Year	If Yes	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Puer (es 2 No specify:		14. Race - American Indian, Bl White, etc.	ack,
2 hours afte "natural" Examine	d by	15. Decedent's Education (Specify	or Dates:		s Usual Occupation (Give kind o	f work done	6b. Kind of Business/Industry	70
136 thin 72 hours aftene. ne. than "natural", ledical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mos	st of working life. DO NOT use re	etired)	City of Baltin	MORE
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be Con	17. Father's Name (First, Middle, La	Wind Bush)	1117	me (First, Middle, Ma	iden Surname)	
D 2121 should be f and Mental 7 is marked	5	19a. Informant's Name/Relationship	(Type, Print)		, '	1 -	er, City or Town, State, Zip Code)	1
e, MD 2 1 and 2 shoul Health and N item 27 is rr		HIDERIA L.	WINDOWSH				20c. Location - City or Town, State	
Baltimore, M bernit. Pages I and 2 Separtment of Health Important: If item 2 njury or other traus		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Speci	3 Removal from State	crematory or othe	on (Name of cemetery, er place)	1,108	Colfefee, UK	
Baltime permit. Pag Department Important: injury or ot		21. Signature of Funeral Service Lic		22. Na	me and Address of Facility //	J.C. Thom	Pagy Liverne	to ite
		23a. Part 1. Enter the disease, or con	olunsion)	3-7-Hoeren	MAIN ST		to Interval
Physician /Medical		failure. List only one cause on	each line.		e mode or dying, such as cardiac	or respiratory arres	Between (
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Probable Electrocution Due to (or as a consequence of					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequence of	of):				
ecuted and - transit	_	events resulting in death) Last	Due to (or as a consequence of d.	of):				
oe exe ician a	dica	UNPENDED	AMENDED					
Box 68760, e death certificate be exe the attending physician ed for use as the burial -	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred Live birth Pregnant at time of d	2 Feta	if death 3 Ectopic preg	nancy	23d. Date of delivery Month Day	Year
Box e death o the atten	ysic	1 Yes 2 No 9 Unkno		eath 5 Oth	er (Specify)			
j, P.O. B ires that the d signed by the	þ	Part II. Other significant condition	s contributing to death but not	resulting in the un	derlying cause given in Part I.		acco use contribute to the cause of	
ords, w requir	etec	,	_			24a. Was ar		
Recor The law icate has I	Completed					autops perform 1 Yes 2	ned? death?	No No
Vital Recoysticant: The latticate by Idirector, page	Be	25. Was case referred to medical examiner?	Hospital:	ER/Outpatient	26.Place of Death (Chec		tesidence 6 V Other: Scene	
Division of Vital Records, rate dear dear require at or Attending Physician: The law require and state death. After this certificate has been si led in by the funeral director, page 2 should b	on: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Deadline	28a. Date of Injury (Month Day, Year)	28b. Time of In	iury 28c. Injury at Work?		ow injury occurred	
Sion Affent death sctor:	cati	2 Accident 5 Pending Investig	ation		1 Yes 2 V No	28f Location /54	reet and Number or Rural Route Nu	mher City
Divi	Certification:	3 Suicide 6 Could n	ot be		, factory, office building, etc.	or Town, Sta		mber, Gity
Division of Vital Records, P.O. Box 68760, rothe Hospital or Artefuling Physician: The law requires that the death certificate be execut within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Medical Ce	29a. Certifier 1 Certifying Phys	cician: To the best of my knowled	dge, death occurre	ed at the time, date and place, a	nd due to the cause		
To T	Med	29b. Signature and title of certifier	and manner stated.		29c. License number	T	29d. Date signed (Month, Day, Yea	r)
		aue\$2_	<u> </u>		O.C.M.E.		January 4, 2008	
10	- 1	30. Name and address of person wh	o completed cause of death (Iter	m 23a)				

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Ana Rubio MD.

31. Date filed (Month, Day, Year) JAN 0 7 2008

ORIGINAL

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death JACQUELYN R. WATTS 01-03-2008 5:55 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGES If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2XF 238-72-4158 63 01/01/1945 NORTH CAROLINA Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h County M Yes 2 □ No MD PRINCE GEORGES **GLENDALE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12207 GUINEVERE ROAD 20769 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2**X**ONo Specify: BLACK Specify: 3K Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)
4 YEARS Elementary/Secondary (0-12) SUPERVISOR GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WALTER RICKETTS THELMA MITCHELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TARA WATTS 12207 GUINEVERE ROAD GLENDALE, MD 20769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HARMONY MEMORIAL PARK01/08/2008 LANDOVER, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS disease or condition resulting in death) Due to (or as a consequence of): STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4_Unknown

Physician /Medical Examiner

burial-tran

the as

use

ed by the a

page 2 s

þ

Completed

Be (

Certification: To

Medical

physician

The law requires that the death certificate be executed

Box 68760.

O

Division or Vital Records. P.

Hospital or Attending

after death.

I Director: A
d in by the fu

within 24 hours aft

To the Funeral D

completely filled in

Physician

/Medical

Examiner

Funeral

Director

show

ns 23a or 28a-f shov must be notified at

r than "natural", or items the Medical Examiner mu

I Hygiene.

and Mental h

of Health of Item 27 is or other tra

= 5 Department of Important: If any injury or once.

filed within 72 hours after death

Pages 1 and 2 should be

altimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

2

Examine Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Was an autopsy performed? /es 24 No

28d. Describe how injury occurred

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No

25. Was case referred to medical examiner? 1 ☐ Yes 2X No 27. Manner of Death 1 Natural

28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 6 ☐ Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

2 ☐ Accident

3☐ Suicide

4 Homicide

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certified Van

D 64874

30. Name and a fire s of person who completed cause of death (Item 23a) (Type, Print)

SHAHAB BAVANI M.D. 10724 LITTLE PATUXENT PARKWAY SUITE 200 COLUMBIA, MARYLAND 2104

State Registrar

31. Date filed (Month, Day, Year) JAN 0 7 2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend#1.PerPhys.a.PerFHPOC1_4-08ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 2, 2008 **Physician** 8:24 Α Carol Jean Wolny Carol J. Wolney /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Mitchellville Villa Rosa Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, Funeral Days 1 ☐ M 2 🖸 F 70 170-30-7593 Pennsylvania 1937 Mar. 28. Director Usual Residence of Decedent tion 1 and 2 should be filed within 72 hours after death with the Maryland and Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2 TXNo MD Prince George's Bowie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20716 1300 Peachwood Ln. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 → Married White Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (124or 5+) Government Nurse 18. Mother's Name (First, Middle, Maiden Surname)
Mary E. Kelker 17. Father's Name (First, Middle, Last)
Alfred Nitsche Be 19a. Informant's Name/Relationship (Type. Print)
Wolny/husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20716 1300 Peachwood Ln. Bowie, MD Eugene D. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1

Buriai 2 □ Cremation 3 □ Removal from State 1/7/2008 Important: I any injury o Crownsville, MD Department MD Veteran's Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Beall Funeral Fome Bowie, MD 6512 NW Crain Hwy. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each inc. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or consequence of): Examiner ANC Sequentially list conditions, if any La Inc. to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician the attending p for use as SBS IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an 1∐ Yes 2 XNo certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one. Other: 4K Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To eral Director: After th filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 □ Yes 2 □ No death. 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide after 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the Hospital o within 24 hours aft To the Funeral Di State Registrar

Richard J. Feldman, M.D. 32. Registrar's Signature 31. Date filed (Month, Day 2008 JAN 04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

itle of certifie

DHMH 17 Rev 1/2001

29b. Signature and

9500 Annapolis Rd.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Suite A-4

29d. Date signed (Month, Day, Year)

Lanham, MD.

20706

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** MATTIE WOLFORD 7, 2008 January 4:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland Memorial Hospital
Social Security Number 6. Security Number If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 234-40-2847 90 Director APR. 4, 1917 VIRGINIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b, County 1 ☐ Yes 2 No ns 23a or 28a-f sh must be notified WV MINERAL RIDGELEY Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROUTE 1, BOX 518-A 26753 U.S.A. items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Black, White, etc. 1 □ Never Married 2 □ Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No þ WHITE 3 ♥ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) h and Mental Hygiene. CELANESE CORPORATION YARN HANDLER & INSPECTOR 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE B. DULANEY BENJAMIN J. GILBERT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a cortant: If item 27 is injury or other trau 92 VICTORIA LANE, FROSTBURG, MD 21532 RODNEY BUSKIRK / GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. SUNSET MEMORIAL PARK 01/12/2008 CUMBERLAND, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 days Immediate Cause (Final Physician ISCHEMIC CEREBROUASCULAR ACCIDENT ACUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ HUPEKTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury within 24 hours after deau..

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifie Medical (Check only

State Registrar DHMH 17 Rev 1/2001

15

nas

29b. Signature and title of certifier

AJA4L, M.D. .
31. Date filed (Month, Day, Year)

JAN 0 9 2008

AJAYI

MEMORIAL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D

D0066606

CUMBERLAND, UD

29d. Date signed (Month, Day, Year)

07/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	State of N	1arylar			nt of He te of E		and M		jiene og No.20	0.8	014	+52
			Decedent's Name (First, Middle, Last)				-				2. Date of Dea	th	Vaar	3. Time of	Death
	Physici /Media		Lawrence Edwa	rd Welc	h						0 ^M °7 th 1	1/2008	Year	2:00	Р м
	Examir		4a. Facility Name (If not institution, give s		-	- 1		, Town, or	Location o	of Death		4c. County			
			Garrett County Men 5. Social Security Number 6. Sex			al last birthday)		land	If Under 2	24 Hrs	C Date of Birth	Garr			. 5
	Funeral Director			IM OFF	87	Yrs.	Months		Hours	Min.	8. Date of Birth	1920		place (State o intry) and Md	r Poreign
	D		Usual Residence of Decedent					1							
	show	_	10a. State 10b. County		10c. Ci	ity, Town or Lo	cation							10d. Inside Ci	•
	Ba-f	octo	MD Garrett			0ak1ano								1 🗌 Yes	2X_1 No
	with th	Dire	10e. Street and Number	1			10f. Z	p Code	2	1550		Og. Citizen of V		intry?	
	ne 23	Funeral Director	2588 Fingerboard Ro	12. Was Deceder	nt Ever in L	IS 13 V	Vas Dece	edent of His						ican Indian,	
(0	r Hen	표	1 ☐ Never Married 2 🕅 Married	Armed Forces	s?					, Puerto	ecify Yes or No- Rican, etc.)		k, White,		
ĕ	ours a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates	s:		I□ Yes	ZL No	Specify:			Specify	Wh	ite	
5-0	within 72 hours after death with the Maryland ane. than "natural", or iteme 23a or 28a-f show fre Modical Exertinat by rodiffed at	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	kind of w	ork done di	urina most	of worki	ng	16b. Kind of Bu	ısıness/lr	ndustry	
121	within the the the the the the the the the the	dm	Elementary/Secondary (0-12)	College (1-4o	ır 5+)		Cler!	use retired)				Gas S	tati	on	
Q 0	Hygis Hygis other 1		4th 17. Father's Name (First, Middle, Last)				TEL		18. Mothe	r's Name	(First, Middle,				
ylan	Mental Mental arked o	To Be	Dewey Miller Weld	ch, Sr							zabeth				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiane. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Modical Exportment read by notified at ange.		19a. Informant's Name/Relationship (Type Evelyn E. Welch	oe, <i>Print)</i> / wife							Oaklan		State, Zij 2155		
nore,	ages 1 a int of He t: If tem f or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from Stat	te C	Place of Dispo-	natory or	other place				20c. Location -			
Ħ	artme ortani Injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libers	• 1	Ga	rrett (wart Fu	Oakland			
B	Ded drag		> 1Stal 1	In							t, Oakl			550	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caus	ed the deaf	th. Do not ente	er the mo	de of dying	, such as	cardiac o	or respiratory arr	est,		Approximate Interval Bety	
	Physician		Immediate Cause (Final disease or condition	acu	ito.	51151	Poli	ch	ess.	t t	ailur	0 -		Onset and I	
	/Medical Examiner		resulting in death)	Due to (or a	as a consec	quence of):	1		1	1					
	Ladininei	_	Sequentially list conditions, b	Due to (or a	le	1,200	ue	uza	14						
	ted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ch 11	ns a conseq	5 4 °	fort	ic 7	hoa.	+	failu	40			
<u>,</u>	cate be executed physician and the burial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or a	as a consec	quence of:	100	nc 1	uecr	0	Duciu	ne			
68760,	sicial /sicial	dical													
89	tificat ng phy as th	Medi													
Вох	eath certific attending p	an/N	23b. Was decedent pregnant	3c. If yes, outcom 1 ☐ Live birth			Ectopic r	regnancy					te of deliv	*	
O.	The law requires that the death certific te hes been signed by the attending p page 2 should be deteched for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant 9☐Unknown			Other (s					Mo	าเท	Day Y	/ear
٥.	that ti ed by detec		Part II. Other significant conditions con	tributing to death	but not res	sulting in the un	nderlying	cause give	n in Part I.	-	23e. Did tol	bacco use conti	ribute to	the cause of d	eath?
Sp	uires Isign Id be	d b	diabetes type	22:1	Derip	Reval	Vas	cula	urdi	SLA	10 Y	es 2 🗆 No	3 Pro	bably 4	Inknown
Ö	w requir been si should	lete	atrial Librilla	ction	-61	malic	L	7	. d-	2 3	24a. Was a	n 24b. V	Were aut	opsy findings	available
Re	The la te hes age 2	Completed by	arrive govern)	_(A)1	ONIC	100	000	4 40		autops perfore	med?	prior to co death?	ompletion of ca 2□ No	ause of
	ian: rtifice tor, p	0	25. Was case referred to medical						26. Place	of Death	1 Yes		I □ Yes	2LI NO	
>	nysica nis ce direc	To B	examiner? 1 Yes 2 No	ospital:	tient 2	ER/Outpatien	3 D	Othou	-		ne 5□Reside		er (Speci	fy)	
0	ng Pl		27. Manner of Death 1 Statural 5 ☐ Pending	28a. Date of In (Month, D	jury Da <i>y Year)</i>	28b. Time of Injury		28c. Injury Work	at ?	1	28d. Describe ho	ow injury occurr	ed		
<u> </u>	Attendii death. ctor: A y the fu	catl	Accident investigation 3 Suicide 6 Could not be				М		es 2 N						
Division of Vital Records,	al or At s after o il Direct id in by	Certification;	4 Homicide determined	28e. Place of li building,	Injury - At h etc. <i>(Specil</i>	ome, farm, stre fy)	eet, facto	y, office			28f. Location (SI City or Town		er or Run	al Route Num.	ber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one)	ician: To the bes er: On the basis and manners	of examina	owledge, death ation and/or inv	occurred	at the time	e, date and inion, deat	d place, a	and due to the ca	ause(s) and ma ate and place, a	nner as s	stated. to the cause(s)
	of the	Me	29b. Signature and title of certifier	and mailler :	3(8180.		29	c. License	number		- 2	9d. Date signed	1 (Month,	Day, Year)	
	->-0		> May savot a	Lais	en 1	20		D260	50			1/12/2	200	8	:
			30. Name and addres of person who con	npleted cause of	l death (Iter	m 23a) (Type, I	,		7	0		eklan			
			margaret a ke	user r	nd 1	13079	ga	rrett	high	huos	24 0	aklan	d.	ud 2	1550
4	Sta Registr		31. Date filed (Month, Day, Year)	32. Regis	strans Signa	ature A	A	10 m	J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 5,2008 **Physician** Charles Williams 3:12 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 ☐ F Director Yrs. 218-20-7696 81 Nov. 5, 1926 Delaware Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Glenburn Avenue 21613 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 20 Married 1 ☐ Yes 2/ No Specity: Specify: black 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) freight truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Williams Bessie Johnson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Blackwell 1504 Riverside Dr., Salisbury, MD p.r. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 1/8/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis month /Medical Due to (or as a consequence of): Examiner colitis month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ dementia 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 □ No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 — Nursing Home 5 — Residence 6 — Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29d. Date signed (Month, Day, Year) anson

Registrar
DHMH 17 Rev 1/2001

State

3

100 Bramble

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2008 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner Memoria Easton Talbot Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F 5 77- 46-3943 Usual Residence of Decedent Yrs. March 1, 1936 Maryland Director 10d. Inside City Limits 10c. City, Town or Location items 23a or 28a-f show artment of Health and Mental Hygjene. ortant: If Nem 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the Medical Examiner must be notified at 1 Ves 2 No Michael Director Talbot 10e. Street and Number 10g. Citizen of What Country? USA 14. Race - American Indian, Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 1 No Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City Public Works Water Meter Reader 17. Father's Name (First, Middle, Last) Be Catherine Wolfe awrence DelMont ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6759 W. Willowbrook Rd Bealeton, Va. Lawrence Delmont Wolfe Department of Hear Important: If the any Iniv. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Mid Shore Cremation Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, R.A. 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. dge, MDi21613 Immediate Cause (Final disease or condition resulting in death) 380519 **Physician** /Medical Due to (or as a consequence of): **Examiner** PNECIMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CANCER BONE METASTATIC burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1∐ Yes 2 🖪 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No After this certificate has 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √No 1 Inpatient 2 ER/Outpatient 3 DOA မ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier outhother D0059487 1/4/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Street, Easton, Md. 219 S John Botsis, M.D.

DHMH 17 Rev 1/2001

State Registrar 9 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 03:07 AM First 2008 Janucary /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and nur 4b. City. Town, or Location of Death Examiner ambridge Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days 220-03-3841 1 □ M 2 😿 F Min Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗷 No Director MD Talbot Trappe 10g. Citizen of What Country? 10e. Street and Number Sanderstown 21673 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 [] No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 🗷 No Specify: Black Specify 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Residence Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Skinner Roi Albert Helen Logan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29149 Sanderstown Road Trappe, Mary land

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State 21673 item 27 i Chiquita
20a. Method of Disposition Warner permit. Pages Department of I Important: If ite any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Paradise Cemetery 8/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funeral Home, P.A. 510 Washington Str Cambridge 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Coronary Disease Artery **Physician** resulting in death) /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) physician by Physician/Medical as IF FEMALE: USe 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year detached for 4☐Pregnant at time of death 5 Other (specify) the 9☐Unknown 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Maryl

Baltimore.

completely filled in by the funeral director, Hospital or Attending within 24 hours a To the Funeral I To the I

State Registrar 31. Date filed (Month, Day, Ye

elinto 2

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Times 200 Byrn Street Cambridge 32. Restrar's Signature

29c. License number

066371

29d. Date signed (Month, Day, Year)

Maryland 21613

11st 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item 25 per verb., g877G92/files/108-th/Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Virginia G. Wright 2008 Januar /Medical 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Memorial Hospital Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In vrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🗓 F 91 Yrs 215-14-3747 **Director** 1916 11, Delaware Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Federalsburg MDCaroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 United States 310 Liberty Road Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify. Specify þ 3K Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Preparation Cafeteria Worker Health and Mental Hygi em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be 1 Gertrude Moore Victor K. Phillips ဥ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Kathleen W. Tull/Daughter 310 Liberty Road, Federalsburg, MD 21632 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important; If it
any injury or o Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery 01/13/08 |Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a conse use of): Examiner Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a collisequ certificate be executed attending physician and for use as the burial-tran-Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No cert ficate 1□ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No To the Hospital or Attending Physical and the Abours after death.

To the Funeral Director: After this completely filled in by the funeral director. P 2 ER/Outpatient 3 DOA ō 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

D \$\$ 656 56 60, M.D n who completed cause of death (Item 23a) (Type, Print) South Washington Street Registrar's Signa State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

amend 1 per Dr. g876 2/21/08 KBH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Abigail Michelle Airey Wroten Month **Physician** 08 Marea /Medical 4a. Facility Name If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easto HOSDITA/@Easton TAIBO memoria 8. Date of Birth (Month, Day, Year) Jan. 8, 2008 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ☐ M 2 🕱 F Hours 20 Maryland N/A Jan. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther then "naturaf, or Items 23s or 28s-f show 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Federalsburg MDDorchester 1 Yes ZINo Director 10g. Citizen of What Country?
United States 10e. Street and Number 10f. Zip Code 21632 6408 Redcrest Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give N / A 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status N / A
1 □ Never Married 2 □ Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White à N/A 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Michelle Karen Airey Charles Garland Wroten, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 93, Federalsburg, MD 21632 19a. Informant's Name/Relationship (Type, Print) Michelle Airey/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Federalsburg, MD Hillcrest Cemetery 01/12/08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 CFSP Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Prematurity Physician Extreme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. | ed by the a detached f 9 Unknown 9 Unknown signed b Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient Certification: To 1 X Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A
completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖟 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) ST. EASTON,

DHMH 17 Rev 1/2001

State Registrar

Michae

31. Date filed (Mont

40

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01-13-2008 Physician LEONARD E. WINFIELD 3:21a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Memorial Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 3, 1947 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months 1 M 2 □ F Director 219-46-0420 60 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b, County Cumberland MD 28a-f sh notified Allegany Yos 2 No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. and the file may be an ant.! file marked other than "natural", or Items 23a or may or other traumatte event, the Medical Examiner must be runy or other traumatte event, the Medical Examiner must be read. 21502 USA 426 Seymour Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 ☐ Never Married Ž☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CSX boilermaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth E. Teter Winfield Robert L. Winfield ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
426 Seymour Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Rita Winfield wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 1/17/2008 Cumberland MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Service Licenses 22. Name Scarpelli Punellal Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a/Pert1 Inter the disease, or compressions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BILATERAL CAROTID STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans PERIPHERAL ARTERIAL DISEASE Division or Vital Records, P.O. Box 68760,৺ Due to (or as a consequence of) Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HYPOTHYROIDISM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an TYPE II DIABETES autopsy performe Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2X ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D09157 JANUARY 14, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 SNOW, M.D. 124 W. THIRD STREET, CUMBERLAND, MD 21502 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 12, Donna Jean Wood 2008 12:50P ^M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick College View Center Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2√2 F Yrs. Director 332-34-6701 01/28/1943 Illinois Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 6391 A. Rutherford Court 21703 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 1 Yes 2 No If Yes, GiveX Year or Dates: 1 ☐ Yes 2 No Specify: Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>homemaker</u> own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Merle Thompson Betty Waldron ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6391 A Rutherford Ct., Frederick, Maryland 21703 George P. Wood, Jr./spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 01/14/2008 Smithsburg, Maryland 22. Name and Address of Facility Keeney & Basford PA Funeral Home 21. Signature of Funeral Service Licensee

Augustic

Likell -M01222106 East Church Street, Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Tue to (1 r as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Orease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Physician/Medical as attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate 2 funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours a

To the Funeral E

completely filled i the

3altimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

State Registrar

MID

DO060417

29c. License number

29d. Date signed (Month, Day, Year) 1-14-08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DV, Frederica MD shah Tohnson Hemen 1 homas

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 5, 2008 2:06 Barbara O. Yost а /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Innofer Year I Under 24 Hrs. Holy Cross Hospital 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours 1 M 2 F Yrs. Director May 8, 1926 470-24-3124 Minnesota Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 V No Director Silver Spring 10f. Zip Code the Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number o e with 1 ns 23a c must be death v by Funeral 9903 Portland Road 20901

as Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 'natural", or Items Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "natural"; or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Head Cashier Electric Company 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Wilford Olson Minnie Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Harry J. Yost/Husband 9903 Portland Road, Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 permit. Page Department o Important: If any Injury or January 11, Fort Lincoln Cemetery 2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Kyla 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Physician Sudden /Medical Due to (or as a consequence of): Examiner Oprovary Artery Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Lines of distributions (Disease or injury that initiated events resulting in death) Last Years Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1∐ Yes 2 🛣No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1x Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division or Vital Records, P.O. Box 68760,

after death I Director:

Filled

To the Hosp within 24 hou To the Fune completely fi

State Registrar

Medical

Suresh K. Gupta, MD

and manner stated.

29c. License number D32332

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

January 6, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801 Georgia Avenue, #220, Silver Spring, MD 20902

31. Date filed (Month, Day, Year) JAN 0 8 2008

29b. Signature and title of de tifier

4 ☐ Homicide

(Check only one)

29a, Certifier

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of	Maryland /		artment tificate			and Me		ieņe	8	014	61
	Physici	an	1. Decedent's Name (First, Middle, L	.ast)							Date of Deat Month	Day	Year	3. Time o	
	/Medi		Margaret R.	Yerger							anuary	3, 200			РММ
	Examir	ner	4a. Facility Name (If not institution, g.		ber)				Location of			4c. County	erse		
	Funeral		11641 Somerset A 5. Social Security Number 6.	Sex 7	. Age (In yrs. last bi	irthday)	If Under	1 Year	If Under	24 Hrs. 1	8. Date of Birth		9. Birth	place (State	or Foreign
	Director		162-10-3945 Usual Residence of Decedent	1□M 2 X F	93	Yrs.	Months	Days	Hours	Min.	(Month, Day,)4-27-19	14	Mary	land	
	aryland show	_	10a. State 10b. County		10c. City, Tov	vn or Lo	cation	-	-					10d. Inside (City Limits
	the Ma	Director	Maryland Somers	et	Princ	ess	Anne 10f. Zip	Code			11	Oa. Citizen of V	What Cou	-,1	2 140
	3a or	Ö	11641 Somerset A	wenne					853				USA	,	
	death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13.	Was Deced			gin? (Spec	ify Yes or No-		e - Amer	ican Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show amy injury or other traumatic event, the Medical Examinating the Inditional Affice.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Dat	10/6		Tes, spec		Specify:	i, i deito i	ican, etc.,	Specify	v.	hite	
21215-0036	72 hou natura	ted t	15. Decedent's (Specify only highest of	Education	= 10-	a. Deced	lent's Usua kind of wor	l Occupa	ition	t of workin	g	16b. Kind of Bu			
121	within ne.	Completed	Elementary/Secondary (0-12)	College (1-	·	life. I	OO NOT us	e retired))	CO WOLKING		T.,,,,,,,,,,, D.		***	
	filed withi Hygiene. other than ent, the M	e Co	12 17. Father's Name (First, Middle, Las	5+ st)	M	anas	ger		18. Mothe	er's Name	(First, Middle, N	Human R Maiden Suman		irces	<u> </u>
/lan	should be fand Mental B s marked of umatic eve	To B	John Baker Rober	ts					He1	en Wa	atts				
Maryland	12 sho h and l 7 Is ma trauma		19a. Informant's Name/Relationship John Roberts/Bro								Route Number,				23227
	s 1 and f Health item 27 other to		20a. Method of Disposition		20b. Place o	of Dispo		ne of	Ī	Da	-	20c. Location -			
Baltimore,	Pages ment of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec		rate	-			.	1/07/	′2008 I	rinces	s An	ne, Ma	ryland
Balt	permit. Depart Import any inj		21. Signature ne al her e Lic	XXX A.	M00295		Name and Inman 1673				Prince	ess Ann	e. M	D 2185	i3
			23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications hat cally one cause on ea	used the death. Do ch line.	not ent	er the mode	of dying	, such as	cardiac or	respiratory arre	est,		Approxima Interval Be Onset and	ate etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Deme	M	ha							/0 -	yes.
	Examiner		1	Due to (o	r as a consequence	of):								(
	p .≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (o	r as a consequence	of):									
	xecute and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consequence	of):									
8760,	sate be executed obysician and the burial-transit	Ical E		d											
9	artifica ing ph e as th		IF FEMALE:			187				- intibute					
.O. Box	The taw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live bir	ome of pregnancy th 2 Fetal death nt at time of death vn		Ectopic pre Other <i>(spe</i>					23d. Dai Mo	te of deliventh	/ery Day	Year
Δ.	quires that the signed by all be detacled	by	Part II. Other significant conditions	contributing to dea	th but not resulting	in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use cont	tribute to		death?]Unknown
Records,	The taw requir te has been si age 2 should	Completed									24a. Was ar autops perform	y ned?	prior to co death?	opsy findings ompletion of 2 No	s available cause of
Vital	ician: The certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 Yes 2 (Check only one		103	20 140	
of V	Physician: r this certifica ral director, i	To B	examiner? 1 ☐ Yes 2 ☑ No		patient 2 ER/O	utpatien	t_ 3 🗆 DO	A Othe	r: 4 □ Nu	rsing Hom	e 5 Aeside	nce 6 □Oth	er (Spec	ify)	
	ling Afte fune		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of (Month)	Injury 28b. Day Year)	Time of Injury	28 M	Bc. Injury Work	at ? ′es 2 🗀		3d. Describe ho	w injury occur	red		
Division	Attending er death. rector: After by the fune	Certification;	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place o	f Injury - At home, f	arm, str			95 Z 🗀		Bf. Location (St		per or Ru	ral Route Nu	mber,
Di	ital or irs afte ral Dire	Cert	4 Homicide	building	g, etc. (Specify)						City or Town				
	To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 ★ Certifying F (Check only one) 1 ★ Certifying F	Physician: To the base aminer: On the base and manne	est of my knowledg sis of examination a er stated.	ie, death nd/or inv	occurred a restigation,	at the tim in my op	e, date an pinion, dea	d place, ar th occurred	d at the time, da	ate and place,	and due	to the cause	
)	To t To t	Σ	29b. Signature and title of certifier	2 2	ARAL,	MD		License		423		od. Date signer)
14	ti ER		30. Name and address of person who	o completed cause	of death (Item 23a)	(Type,	Print)	M	り	21	851				
15	Sta		31. Date filed (Month, Day, Year)	32. Re	strar's Signature										
	Registi	ŗar	JAN 0 8	2008	lean b	1	bout	_							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Yandrofski January 5:00 p.M 2008 /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 518 Glenburn Avenue Apt. 102 Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2X F Director 197-24-7979 91 June 14, 1916 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Dorchester Director MD Cambridge 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 518 Glenburn Ave. Apt. 102 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white þ 3 □ Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home Pages 1 and 2 should be filed nent of Health and Mental Hygint; If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Shostak Pauline Walko မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Yandrofski son 7 Dutch Creek Drive, Littleton, CO 80123 20b. Place of Disposition (Name of cemetery, crematory or other place)
Transfiguration 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important; If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State West Hazleton, PA Church Cemetery 170700 22. Name and Address of Facility Thomas Funeral Home P.A. 1/8/08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclero he disease Heart **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, fractions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. <u>Ş</u> þe 1 | Yes 2 | No 3 | Probably 4 | Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Mo 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 27 10 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending P 4 hours after death. Funeral Director: After t tely filled in by the funera 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

29h. Signature and title of certifier

NOMAN

BYRN THARWY 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

503

JAN 0

29c. License number

D 47924

CAMBRIDGE

29d. Date signed (Month, Day, Year)

1-3-08

15

State Registrar 31. Date filed (Month, Day, Year)

JAN 08

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

VII

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 4, 2008 2:32 Irene Justine Youngman January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examine **Funeral** Director

Α

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

a:32 Am &

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

⊏xamır	lei	Suburban Hospita	1			Bethe	sda			Mont	gomery	
ineral rector			Sex 1 □ M 2 X F	7. Age (In yrs. 9	V/==	If Under 1 Ye Months Da		Min.	Date of Birth (Month, Day, Ye pril 14	ar)		(State or Foreign
a-f show fied at	tor	Usual Residence of Decedent 10a. State Maryland Montgome	ry		y, Town or Lo	cation						nside City Limits ☐ Yes 21 No
3a or 28a st be noti	al Director	10e. Street and Number 10234 Democracy B	oulevar	·d		10f. Zip Cod 2085					What Country?	
al", or items 2 xaminer mu	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed F	2⊠No ive		Was Decedent of Yes, specify 0	uban, Mexic	an, Puerto Rica	Yes or No- an, etc.)	Bla	ce - American Inck, White, etc. fy: White	
nan natura te Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ade completed)) (1-4or 5+)	(Give life. L	dent's Usual Oc kind of work do DO NOT use re	ne durina ma	ost of working	166	Own]	Business/Industr	у
tic event, th	To Be Co	17. Father's Name (First, Middle, Last Paul Morel	-		но	memaker		·	rst, Middle, Mai Lthuralo	den Surnai		
her trauma		19a. Informant's Name/Relationship (Carole Y. Prest (1023	4 Democ	racy B	Boulevar	rd, Poto	omac,	MD 2085	54
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>		20a. Method of Disposition 1 □ Burial 2 □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	(h)	0	tropol:	2. Name and Ad	dress of Fac		y 8, Al Al Ol Fune:	lexano		irginia
# E 5		23a. Part . Enter the dis. ase or con shock, or heart tail re. List only	nplications that	caused the death					e, Gaith espiratory arrest,		Apr	20877 proximate erval Between
ician dical niner		Immediate au (Fin disease or condition resulting in death)	Ath	eroscle:	rotic '							set and Death
igned by the attending physician and be detached for use as the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequence of the consequence)								
ched for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live	utcome pf pregna birth 2 Feta pnant at time of d nown	ıl death 3□]Ectopic pregna] Other <i>(specif</i> y					ate of delivery onth Day	Year
id be deta	b	Part II. Other significant conditions	contributing to c	death but not resi	ulting in the ur	nderlying cause	given in Par	t I.	23e. Did tobac	co use cor	ntribute to the ca	
cernicate nas been s rector, page 2 should	Completed								24a. Was an autopsy performed 1∐ Yes 2 ∑	1?		findings available tion of cause of
ector,	Be	25. Was case referred to medical examiner?	Hospital:				Other:	ce of Death (C				
I to the Funeral Director: After this certificate in completely filled in by the funeral director, page	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date (Moi		ER/Outpatien 28b. Time of Injury	28c.	njury at Vork?	28d	5 Residenc			
al Director	Certification:	3 Suicide 6 Could not be determined	200. Flac	e of injury - At ho ding, etc. <i>(Specif</i>	ome, farm, str	eet, factory, off	ce	28f.	Location (Stree City or Town, S		ber or Rural Ro	ute Number,
ne runer oletely fill	Medical	29a. Certifier 1 🗘 Certifying P (Check only 2 Medical Exa	miner: On the I	e best of my kno basis of examina nner stated.	owledge, deatl ation and/or in	h occurred at th vestigation, in r	e time, date ny opinion, d	and place, and leath occurred	I due to the caus at the time, date	e(s) and m and place	nanner as stated , and due to the	l. cause(s)
COM	M	29b. Signature and the of certifier	W		00.1	D	(2	949		_	ed (Month, Day,	
		30. Name and Address of person who Natasha Haag, M.	7 1	ose of death (Item			l, Bet	hesda,	MD 2081	_4		
Sta Regist		31. Date filed (Month, Day, Year) JAN 0 7 20		Registrar's Signa	ature	W.						
		J			-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** William Thomas Adcock January 14, 2008 8:10 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2929 Louisiana Avenue Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Mary Land 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Jun. 7, 7. Age (In yrs. last birthday) **Funeral №** M 2□ F 212-42-5057 62 Jun. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show notified at 1 ☐ Yes 2X No Director MD Baltimore Baltimore -28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 2929Louisiana Avenue 21227 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 💹 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Freight 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Russell Adcock ၉ 19a. Informant's Name/Relationship (Type. Print) Dana Dettmer – Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6014 Baltimore Street, Baltimore, MD 21207 20a. Method of Disposition Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Weter ans Cemetery 4 □ Donation 5 Other (Specify) (d Crownsville 1-22-2008 | Crownsville, MD 21. Signal e of Funeral 6 22. Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician **Physician** Lung Transplant Acute Rejection disease or condition resulting in death) 10 years /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 month Due to (or as a consequence of) attending physician and for use as the burial-transi Lung Transplant 10 years Due to (or as a consequence of) P.O. Box 68760 death certificate be Physician/Medical Emphysema (COPD) 20 vears IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 22 No 1⊟ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 💢 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Edward James Britt, 22 South Greene STreet, Baltimore, MD 21201 Registrar's Signature

D21930

January 23, 2008

ORIGINAL

Fun Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f ehow

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box $68760\%_{\omega}$

	1- State Registrar Cert	rificate of Death Reg. No.
	1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
an	Anna Rose Agnello	January 19, 2008 1:00 P
al r	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
	4650 Alcott Way Unit 104 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Owings Mills Baltimore If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9, Birthplace (State or Foreign
	218-32-9722 1 M 2 XX 89 Yrs.	Months Days Hours Min. (Month, Day, Year) Country)
	Usual Residence of Decedent	November 05, 1918 Maryland
	10a. State 10b. County 10c. City, Town or Local	ation 10d. Inside City Limit
Ö	Maryland Baltimore Owing	s Mills 1□Yes 2√∏N
Directo	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
=		
<u>a</u>		21117 United States of Americ
Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. W	as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
by F	1 Never Married 2 Marned 1 Yes 2 No If Yes, Give XX Year or Dates.	☐ Yes 2☐ No Specify: Specify:
	AA	XX White
Completed	15. Decedent's Education (Specify only highest grade completed) (Give k	nnt's Usual Occupation 16b. Kind of Business/Industry ind of work done during most of working 0 NOT use retired)
ם	Elementary/Secondary (0-12) College (1-4or 5+)	JNOT use retired)
		ne Maker Own Home
e C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
0	Frank Maranto	Mary Maggio
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	Gloria Cantrell (Daughter) 4650	Alcott Way, Unit 104, Owings Mills, Md 21117
	20a. Method of Disposition 20b. Place of Disposi	
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn	
	21. Signature of Funeral Service Licensee 22.	Name and Address of Facility
	1 K-00-00 1/06333	Name and Address of Facility. Loring Byers Funeral Directors,
_	23a. Party. Enter the disease, or complications that caused the death. Do not enter	<u> 28 Liberty Road, Kandalistown, MD, 21133 — </u>
	shock, or heart failure. List only one cause on each line.	Interval Between Onset and Death
	Immediate Cause (Final disease or condition	structure Lun, Discesse
	resulting in death) Due to (or as a consequence of):	
	Sequentially list conditions, b.	
Examiner	if any leading to immediate Due to (or as a consequence of):	
Ē	cause. Enter Underlying Cause (Disease or injury that initiated events c.	
Ä	resulting in death) Last Due to (or as a consequence of):	
/Medical	d	
B		
_	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
rnysiciai	in the past 12 months?	Ectopic pregnancy Other (specify) Month Day Year
S	1 Yes 2 No 9 Unknown 9 Unknown	
	Part II. Dther significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
2	The same of the sa	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow
5		ILITES ZUNO SETTIODADIY 4 DUNINO
Completed		24a. Was an autopsy findings availal autopsy prior to completion of cause of
5		autopsy prior to completion of cause of death? 1 □ Yes 2₽No 1 □ Yes 2₽No
0	25. Was case referred to medical	26. Place of Death (Check only one)
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other
	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?
	1. Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 □ Yes 2 □ No
)	3 Suicide 6 Could not be 28e Place of Injury - At home farm street	
	4 Homicide determined building, etc. (Specify)	City or Town, State)
2		
		occurred at the time, date and place, and due to the cause(s) and manner as stated.
	(Check only 2 Medical Examinar: On the basis of examination and/or inve	estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	(Check only 2 Medical Examinar: On the basis of examination and/or invenee) Additional Examinar: On the basis of examination and/or inveneen	
	(Check only 2 Medical Examinar: On the basis of examination and/or inve	estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)
	(Check only one) 2 Medical Examinar: On the basis of examination and/or inverse and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	(Check only one) 2 Medical Examinar: On the basis of examination and/or inverse and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year) P 2 2 0 8 5 J Course 21 200
	(Check only 2 Medical Examinar: On the basis of examination and/or inverse and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, P	29c. License number 29d. Date signed (Month, Day, Year) D 2 9 0 8 5 Tomas, 21 200
Medical	(Check only one) 2 Medical Examinar: On the basis of examination and/or invegand manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, P	29c. License number 29d. Date signed (Month, Day, Year) D 2 9 0 8 5
Medical Certification:	(Check only one) 2 Medical Examinar: On the basis of examination and/or invegand manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, P	29c. License number 29d. Date signed (Month, Day, Year) D 2 9 0 8 5

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Patricia Jean Alfaro $Ja^{MOnth}_{ary} 20^{y}$, 2008° 3:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1211 N. Main Street Hampstead Carrol 1 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 26, 1 7. Age (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Hours Days 1 ☐ M 2 🔀 F 217-46-0565 Director 60 1947 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits r 28a-f shov notified at Maryland Carroll Director Hampstead 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 1211 N. Main Street 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23204 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🍇 ☐ No Completed by Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hampden Elementary/Secondary (0-12) College (1-4or 5+) Moving and Storage 8 Packer Pages 1 and 2 should be filed went of Health and Mental Hygiennent: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kisner James Helen Heinbaugh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alfredo Alfaro 1211 N. Main Street, Hampstead, Maryland 21074 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 1/25/2008 Fullerton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211
3631 Falls Road, Baltimore, Maryland 21. Signature of Juneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Parkinson Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Gause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) I ☐ Yes 2 ☑ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy performed? 2 **∑** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? after death. 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

0060503

Hempstead, MD 21074

1/22/08

MO

32. gistrar's Signature

HAnover

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2111

Amy Steritz MiD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 Rosetta anyary В. Armstrong 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Doctor's Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Florida 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 M 2 X 80 259-60-7606 11/08/1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2□No MD Prince Georges Laurel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 11304 Old Cistern Lane 20708 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes Ž☐ No Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educator Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Tsiah Harris Katie Douglas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deidra L.Fryer/ Daughter 11304 Old Cistern Lane Laurel, MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Riverside Cemetery 1/25/08 Albany, Georgia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Hm 21. Signature of Funeral Service Licens 108 West North Ave.Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atheroscleratic Heart disease or condition resulting in death) ear. Due to (or as a consequence of): remonia andiac ourythmig Due to (or as a consequence of): En cephalopathy 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown

Physician /Medical Examiner

and

burial-

the as

use

attending physician for use as the buria

the

ģ

this certificate

After thi funeral of

Director:

death.

after

within 24 hours a To the Funeral C

certificate be executed

Box 68760.

P.O. I

Records,

or Vital

Division or Attending Examiner

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

a or

7 Is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must

1 and 2 should be filed within Health and Mental Hygiene. Iem 27 Is marked other than

item 27

permit. Pages 1
Department of H
Important; If ite
any Injury or ot
once.

Baltimore, Maryland 21215-0036

23a

Director

Funeral

þ

Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No autopsy performed 2 X No

3 Probably 4 Unknown

24a. Was an 26. Place of Death (Check only one) 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

30. Name and address of person who completed

5 Pending investigation

6 ☐ Could not be determined

Hospital: 1 Inpatient 28a Date of Injury

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23e. Did tobacco use contribute to the cause of death?

29a. Certifier

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

D20108

29d. Date signed (Month, Day, Year)

State Registrar

Fox Lone, Suite 222, Bowje, MO. Kakesh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ohnnie Anderson	1- For State C6	ertment of Health and Mental Heartificate of Death	Reg. No. 2000 014/
Physician Medical Examine			2. Date of Death Month Day Year January 14, 2008 3. Time of Death 0844 hrs
L-l-	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	
_	8950 River Island Dr.	Savage	Howard
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 1X M 2 F	1381 birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	- I
any	Usual Residence of Decedent 10a. State 10b. County 10c. Cit	y, Town or Location	10d. Inside City Limits
* .	MD Howard	Savage	1 Yes 2 X No
the Maryland a or 28a-f show lifted at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
with the Maryland s 23a or 28a-f sho c notified at once.		U.S. 13. Was Decedent of Hispanic Origin? (Sp	USA pecify Yes or No- 14. Race - American Indian, Black,
r death with , or items 23 r nust be no	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Yeer	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify:	
urs afte tural" amine	or Dates:	16a. Decedent's Usual Occupation (Give kind of v	Specify: white vork done unk 16b. Kind of Business/Industry unk
5-0036 ed within 72 hour lygiene. other than "natt by Medical Exa	Elementary/Secondary (0-12)	during most of working life. DO NOT use reti	red)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Surname)
be fill be fil	William Anderson		Jirginia Bailey
D 21 should and Me 7 is ma	I .	,	Rural Route Number, City or Town, State, Zip Code)
and 2 sho lealth and tem 27 is traumati	William Anderson/brother 20a Method of Disposition 20b	Place of Disposition (Name of cemetery,	Date 200. Location - City or Town, State
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Panells Hygient In the Maryland Important! If litem 213a or 28a-f she important! If litem 21 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Re Commissed by Firmeral Director	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state	crematory or other place)	
Ball permit Depart Impor	21. Si nature of Funeral Services icensee Marie Difecto		d 655 W. Baltimore Street
Physician	23a. Part I. Enter the disease or complications that caused the deat	Baltimore, MD 2120 th. Do not enter the mode of dying, such as cardiac of	r respiratory arrest, shock, or heart Approximate Interval
/Medical	failure. List only one cause on each line. Immediat cause (Final disease a. Atherosclerotic Cardio	ovascular Disease	Between Onset and Death
.ammer	or condition resulting in death) Due to (or as a consequence	of):	
ַ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):	
ted Insit Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence	of):	
50, te be executed systcian and burial - transit			
50, te be execu ysician an burial - tr		200000	22d Data of delivery
Division of Vital Records, P.O. Box 68760, within 24 box box 68760, but Hospital or Attending Physician: The law requires that the death certificate be executed within 24 box as after death. To the this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi edical Certification: To Be Commisted by Physician/Medical Expedical Certification:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	2 Fetal death 3 Ectopic pregna	23d. Date of delivery ancy Month Day Year
by the att iched for Physic	3 Olikilowii		
ires that the signed by I be detach		resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ✓ Probably 4 Unknown
Records, The law requires ficate has been signage 2 should be			24a. Was an 24b. Were autopsy findings available
COF			autopsy prior to completion of cause of death?
of Vital Records, ig Physician: The law requint the this certificate has been sineral director, page 2 should the Commolether.		26.Place of Death (Check	1 Yes 2 No 1 Yes 2 No
Vital ysician his certi directo	examiner? Hospital:	Other	ng Home 5 Residence 6 ✔ Other: Scene
ing Phys After this funeral di		28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
sion trendi death. rtor:	1 V Natural 5 Pending 2 Accident Investigation	1_ Yes 2_ No	
Division ospital or Attending hours after death. neral Director: After filled in by the function:	3 Suicide 6 Could not be determined (Specify)	home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Division To the Hospital or Attent within 24 hours after death within 24 hours after death. To the Funeral Director: completely filled in by the Medical Certification		edge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a	
F S F S E	and manner stated. 29b Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Tati Um - Pollet	O.C.M.E.	January 16, 2008
	Name and address of person who completed cause of death (Ite Patricia Aronica-Pollak MD. Assistant Medical	Examiner 111 Penn Street, Baltimor	re, MD 21201
State Registra	1011 0 1 0000 16	ature	
DHMH 17 Rev 1/2001		ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1245 AM Delores 6 Brown aı 800b /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A University of Maryland Medical Center 8. Date of Birth Month, Pay, Year Apr 18, 1940 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Hours 1□M 2XF Months Days Maryland 67 Yrs. 219-38-6320 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hyglene. and the firem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show urry or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Directo Maryland Baltimore Windsor Mill 10e. Street and Number 10g. Citizen of What Country? USA 7412 Lesada Drive, Apt#2B 21244 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Thomas Phillip White 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rhona A. Blackwell, Daughter 7412 Lesada Drive Apt#2B Windsor Mill, Maryland 21244 Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 01/23/08 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Censee
Thomas Gregory Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Multiple Myeloma **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underly Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Ketroperitoneal Hematoma 1 Yes 2 No 3 Probably 4 Unknown Acute Renal Fallure 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an cate has page 2 s autopsy 2 No certificate 1☐ Yes 25. Was case referred to medical director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Il Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my oninion, death accurred at the 29a. Certifier Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1336357185 31/28 O . \mathcal{M} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Wendell

Jorathan

31. Date filed (Month, Day, Year) JAN 2 4 2008

23

South

32. Registrar's Signature

Greene Street, Baltimore, MD

3. Time of Death

Birthplace (State or Foreign Country)
 NEW YORK

Approximate Interval Between Onset and Death

10d. Inside City Limits 1 ☐ Yes 2 No

11:30AM

		1	For State Registrar		Olato C	71 1410	ai y iai ic				Death	110 11	iomai i i	Reg.			
	Physicia /Medica		1. Decedent's Nar STELL?		, Last) BLAZE	JAK	ζ						2. Date of D		Day 2	208	3. Time
	Examine				, give street and пи				4b. City,	Town, or	Location of	Death				nty of Death	
		*			UER ROA	D					ILLE			BALTIMORE			RE
HE.	Funeral Director		5. Social Security 221 – 10 -	-2822	6. Sex 1 ☐ M 2 ½ F	7. Age	e (In yrs. la 9	st birthday, 2 Yrs.	If Unde Months	Days	If Under 2 Hours	4 Hrs. Min.	8. Date of B (Month, E 4 – 1 1	av. Ye	15	9. Birthp Coun NEW	
	P .		Usual Residence	1													
	ylar	.	10a. State	10b. County			10c. City,	Town or L	ocation							1	0d. Inside
	with the Maryland a or 28a-f show be notified at	덩	MD	BA	ALTIMORE	0			F	KING	SVILI	ĿΕ					1 □ Y
	r 28	<u>e</u> [10e. Street and N						10f. Zi	Code				10g.	Citizen o	f What Coun	itry?
	death with the Maryland ms 23a or 28a-f show must be notified at	<u>a</u>	12208	GLENBAU	JER ROAL)				210	87					U.S	.A.
	after or ite	by Funeral Director	_	ried 2 Marri	5. 13.	Was Dece If Yes, spe 1 ☐ Yes		ispanic Origin, Mexican, Specify:	in? (Spe Puerto	ecify Yes or N Rican, etc.)	lo-		ace - Americ lack, White,				
21215-0036	72 hour	eted b	Year or Dates: 15. Decedent's Education (Specify only highest grade completed)						dent's Usu	al Occupa	ation during most	of worki	ing	16b	. Kind of	Business/Ind	
2121	d within giene.	Completed	Elementary/Sec	ondary (0-12)	College (1-4or 5	+)	life.		se retired IEMA					O	NN HO	ME
	華工 養 品	Re C	17. Father's Name		,						18. Mother	's Name	(First, Middi	e, Maio	den Surn	ame)	
اع	9 to 2 to 2 to 3 to 3 to 3 to 3 to 3 to 3	9	JOHN		MENTROV	ICF	Ŧ				KAI	HAH	RINE		((CZER	W)
Maryland	12 sho		19a. Informant's NANCY		nip (Type. Print)	אוומ	SHTER				and Number		al Route Num				
-	1 and Health em 27 ther t	-			(0.0.0.1.)	7,100					MINGOT					LE,	
<u>o</u>	it of			Cremation	3 □Removal from	State	20b. Pla	ace of Disponentery, cre	matory or	me or other plac			Date	1		n - City or To	
Ë	nit. Pa artmer ortant: Injury		4 ☐ Donation	5 ☐ Other (Sp	ecify)		DULA	NEY	VALI	EY	MEM:		80-3			MUIN,	
Baltimore	permit. Depart Import any Inj once.		21. Signature of F	uneral rervice t	icensee						ss of Facility		CH/RC		DALE.		ERAL 212
		-									-	_			,		

Examiner

Physician/Medical

ð

Completed

Be

Certification:

Medical

Physician

/Medical Examiner

attending physician and for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Attending Physiclan:

To the Hospital or Attence within 24 hours after death To the Funeral Director:

NANCY J. DeANGELIS DAUGHTER 12208 GLENBAUER RD KINGSVILLE, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-25-08 TIMONIUM, MD DULANEY VALLEY MEM

22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnar
in the past 12 months?

1 ☐ Yes 2 ☐ No

9 Unknown

regnant

6 ☐ Could not be

23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 4☐Pregnant at time of death 9□Unknown

3 Ectopic pregnancy 5 Other (specify)

3□ DOA

23d. Date of delivery Day Year

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

24a. Was an autopsy pertormed yes 2 No 1□ Yes

1 🗌 Yes

24b. Were autopsy findings available prior to completion of cause of death?

2 No 3 Probably 4 Unknown

FIBRILLATION AL 25. Was case referred to medical examiner?

26. Place of Death (Check only one, Other: 4 Nursing Home

2 1 No 1 ☐ Yes 5 MResidence 6 □Other (Specify)

1 ☐ Yes 2 ☐ No 27. Manner of Death 1 Watural 5 Pending

28a. Date of Injury (Month, Day Year) investigation

28b. Time of 28c. Injury at Work? 1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RUN RO',

28d. Describe how injury occurred

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title-of certifier

MD

29c. License number D8015022 29d. Date signed (Month, Day, Year) 01/22/08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEODULO

617 STEMMERS BALTIMORE,

State Registrar

NALIAN, Registrar's Signature 31. Date filed (Month, Day, Year) 4

DHMH 17 Rev 1/2001

08-00473 Gregory Banks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 01473

			1- For State Certificate of Death Reg. No.														
	Physicia		1. Decedent's Name	(First, Middl	e,Last)					2	. Date of D		Van	. 1	Time of Death		
Vlec	lical Exami	ner	Gregory	Ban	ks						Month January	17, 2			1005 hrs		
A. 2 -			4a. Facility Name (if			umber)	41	c. City, Town, or	Location o				4c. County o	f Death			
			1620 Druid H					Baltimore						N/A			
	F		5 Amisi Samunity No	miren	6. Sex	7. Age (In yrs. I	ast hirthday)	If Under 1 Yea	r If Unde	r 24Hrs	8 Date of	Date of Birth(MM/DD/YYYY) 9. Birthplace (State					
	Funeral: Director	ł	5.294590×3 478-01-32	303				Months Day	\rightarrow	_				Foreign			
	Director		470-01-32	.04	1 X M 2 F	4	+1 Yrs.				JAN	18	1966	Count	^(y) M D		
			Usual Residence of	Decedent													
	any		10a. State	10b. County		10c. City,	Town or Location	n							d. Inside City Limits		
	nd show	٦	MD	N/	A	1	Baltimor	e						1	X Yes 2 No		
	Maryland 28a-f show d at once.	퓽	10e. Street and Num	nber				10f. Zip Code				10g.	Citizen of Wh	at Country	?		
	e Ma or 25	Director	1620 D	and III	ill Avenu	_		21202					TTC: 4				
	death with the Maryland or items 23a or 28a-f sho must be notified at once.	<u>=</u>		ата п		cedent Ever in U	0 10 11/-	21202 Decedent of Hi		:-2 / 0	eif . Van ar	Ne	USA	American	Indian, Black,		
	th w tems	Funeral	11. Marital Status1 Never Marrie	d 2 X M				s, specify Cuba				NO-	White		I IIIQIaII, Diack,		
	or i	ᆵ			1 Yes	2 🗶 No								70.7			
	afte		3 Widowed		orced If Yes, Give Ye or Dates:			Yes 2 X No					Specify:	Bla			
	nours	Completed by			cify only highest gra			s Usual Occupa st of working life				16	6b. Kind of Bus	siness/Indi	ustry		
	6 72 1 an "	et	Elementary/Secor	ndary (0-12)	College (1-4 or 5+)		_			,	ļ		_			
	or thin	티	11				Cafete	ria Wor					Hospit		7		
	5-0 led v Hygi oth		17. Father's Name (I	First, Middle,	, Last)				18. Mother	s Name (I	First, Middl	e, Mai	den Surname)				
	21 be find I liked	Be	UNK		Banks				Glo	ria	Sam	pso	n		A-545-A-00		
	ould ould H Me	ျ	19a. Informant's Nar	ne/Relations	hip (Type, Print)		19b. Mailing	Address (Stre	et and Num	ber or Ru	ral Route I	dumbe	r, City or Tow	n, State, Zi	ip Code)		
	AD 2 sh and 12 i 72 i mari	- 1	Frieda Ba	nks -	Wife		1031	W. Balt	imore	St.	, Apt	. C	, Balt	imore	, MD 21223		
	Healt		20a. Method of Disp				Place of Disposi	tion (Name of ce	metery,		Date	2	0c. Location -	City or To	wn, State		
	it of it. If other				n 3 Removalit	Tom State	crematory or oth		.	1 /00	10000		Pol+i	moro	MD		
	timer ram		4 Donation 5	Other S	pecify:	met	ro Crem	atory,	inc.	1/23	/2008		Balti	nore,	FID		
	Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	. 1	21. Signature of Fun	1. Signature of Funeral Service Licensee H. Williams 22. Name and Address of Eacility Cremation Society of Maryland, Inc.													
			299 Frederick Road, Baltimore, MD 2														
	Physician		23a. Part I. Enter the failure. List only			caused the death	. Do not enter th	e mode of dying	, such as c	ardiac or i	respiratory	arrest	, snock, or hea	111	Approximate Interval Between Onset and		
*	/Medical xaminer	1	Immediate Cause (F		Committee	ions of Huma	an Immunode	eficiency Vir	us						Death		
	Adminici		or condition resulting	g in death)	Due to (or as	a consequence o	of):										
			Sequentially list con	ditions.	b												
		ē	if any, leading to imi	mediate		a consequence o	of):										
7		Examiner	cause. Enter Under (Disease or injury th	at initiated	С		. ()							_			
	isi. a	Xa	events resulting in d	leath) Last	Due to (or as	a consequence of	or):										
V	8760, ificate be executed g physician and s the burial - transit				d. AMENDED	5 per f	h o875	1-31-08	17t								
	be ex ician irial	n/Medical	UNPENDED		AMENDED) per i	n gora	1 31 00	V L								
	8760, ifficate be	/Ne	IF FEMALE:	research in th		, outcome of preg							23d. Date of	,			
		an	23b. Was decedent p past 12 months?		I Live	birth		al death 3	Ectopio	c pregnan	су		Month	Day	/ Year		
	that the death certifined by the attending detached for use as	Physicia	1 Yes 2 N	n 9 Un		nant at time of de	eath 5 Oth	er (Specify)									
	the de	Ę,	Description of the latest terminal term		a _ Ouki	nown					100- D		1	huse to the	e cause of death?		
	P.O.	by F	Part II. Other signif	icant condit	tions contributing	to death but not r	esulting in the u	naeriying cause	given in Pa	art i.							
	ires that signed	פ									1	Yes	2 No 3	Probac	oly 4 💽 Unknown		
	Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed									24a. W	as an Itopsy			psy findings available appletion of cause of		
	CO law has e 2 s	E G									pe	erforme	ed?	leath?			
	Re The ficate	Ŝ										es 2	V No 1	Yes	2 No		
	tal Rec cian: The certificate ector, page	Be	25. Was case referre examiner?	ed to medica	Hospital:				e of Death	-							
	hysta this	힏	1 ✓ Yes 2	2 No		Inpatient 2	ER/Outpatient		Other ₄		Home 5		esidence 6		Scene		
	Ing Ph		27. Manner of Death	1	28a. Dat (Mon	e of Injury th, Day,Year)	28b. Time of Ir	'' I _	ury at Work		28d. Descri	ibe hov	w injury occurr	ed			
	Sion Attendir death. ector: by the f	읥	1 V Natural 2 Accident	5 Pen	ding stigation			1	Yes 2	No							
	r Ati ter d irect	ij	3 Suicide		Id not be 28e. Pla	ce of Injury - At h	ome, farm, stree	t, factory, office	building, et	tc. 2				er or Rura	Route Number, City		
	Division or A spital or A sours after seral Direction of the filled in B	Certification:	4 Homicide		rmined (Specify)				- 1	or Tow	n, Stat	te)				
	Division Hospital or Attence 24 hours after death Funeral Director: stely filled in by the		29a. Certifier	Certifying P	hysician: To the be	est of my knowled	dge, death occur	red at the time	date and nla	ace, and o	due to the r	ause	s) and manner	as stated			
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a.	Medical	(Check only one) 2	Medical Exa	miner: On the basis	of examination a	and/or investigat	on, in my opinic	n, death oc	curred at	the time, d	ate an	d place, and c	lue to the	cause(s)		
	To the within To the complet	Jed	29b. Signature and		and manner	stated.			se number				29d. Date sign				
		-	A signature and	A COUNTRY					.M.E.						., _ a,, . sai/		
			Yamile?	Prut	half. Mi)		0.0	.IVI. □ .			_ '	January 18	, ZUUÖ			
•	7		30. Name and addre	ess of person	who completed ca	use of death (Iter											
	\mathcal{L}		Pamela E. S	Southall, N	ID Assistant	Medical Exa	aminer 11	1 Penn Stree	et, Baltin	nore, M	D 21201						
	S	ate	31. Date filed (Month		32.	egistrar's Signat	ure d	of contract of the contract of									
	Regis			an 24	2008 🛚 🔏	Belleva A	A AM	A STATE OF THE PARTY OF THE PAR									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Sta	ite	Rosalyn Juerpensus	1650 Oric	eans Street	Johns Hoj	okins CRB	I-186 G	Balti move	, Mar	yland
	(3)			rompland cause of de	eath (Item 23a) (Type	Print)	0203		Januar		71221
	To the Ho within 24 To the Fu	Medical	29b. Signature and title of certifier	and manner sta	examination and/or inted.	29c. License			date and place, 		
Div	To the Hospital or A within 24 hours after of the Funeral Direct prompletely filled in by		4 Homicide determined 29a. Certifler (Check only 2 Medical Exam	building, etc	c. (Specify) of my knowledge, deat	h occurred at the tir	ne, date and place,	City or Tow	n, State)	anner as s	stated.
Division or Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat prompte the funeral director, page pompletely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	y 28b. Time o	f 28c. Injur Worl		28d. Describe h	now injury occur	red	al Route Number,
Vit.	yslclar s certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatier	nt 3 DOA Oth	26. Place of Deat er: 4 ☐ Nursing Ho	th <i>(Check only on</i> one 5 X Resid		er (Speci	(fv)
al Rec	2 33	Completed						24a. Was a autop perfor	rmed?		opsy findings available ompletion of cause of
	The law requires that the ate has been signed by the bage 2 should be detache	by	Part II. Other significant conditions o	ontributing to death bu	not resulting in the u	nderlying cause give	en in Part I.	1 🔀 Y	∕es 2□No	3 ☐ Pro	the cause of death? bably 4 Unknown
P.O. Box 6	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3 time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>			Mo	te of deliv	Day Year
68760,	ificate be executed graphysician and st the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of): a consequence of):						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or sing shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a lung	cancer a consequence of):	tor the mode of dyn	g, suom as caratac	or respiratory an			Interval Between Onset and Death 3 months
■ Balt	permit. Pages Department of Important: If II any Injury or o		21. Signature of Funeral Service Licenta	ryland		Home, Inc. Approximate					
Baltimore,	Pages 1 ament of He ant: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ★ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dispondermetery, credit Hilltop S		rp. 1/23	Date 3/08	20c. Location -		
	l and 2 sh Health and Im 27 Is in Ther traum		19a. Informant's Name/Relationship (Tary Baracco/Daugl	,		ng Address (Street : Manor Rd		al Route Numbe Arm, Mar			o Code)
Maryland	2 should be and Mental Is marked or raumatic eve	To Be		Goeller				Wilhemi		dbou	
	filed wi Hygien other th		9 17. Father's Name (<i>First, Middle, Last</i>)			Renov	ator 18. Mother's Nam	e (First, Middle,		l Est	tate
21215-0036	within 72 ho iene. than "natur the Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work f)	sing	16b. Kind of Bu		
920	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Yeer or Dates:	lo	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Specify	k, White,	can Indian, etc. White
	ath with \$ 23a or rust be		13209 Manor				21057		1	US/	
	the Ma 28a-f s notified	Director	Md. Balt	imore		Glen 10f. Zip Code	Arm		10g. Citizen of V	Vhat Cou	1 ☐Yes 2 💢 No
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
ı	Funeral Director		218-28-0536	M 2⊠F	74 Yrs.	Months Days	Hours Min.	May 24,	7, Year) 1933	Coui	yland
			13209 Manor 5. Social Security Number 6. S		e (In yrs. last birthday)	Gle If Under 1 Year	n Arm If Under 24 Hrs.	8. Date of Birtl	h I		timore place (State or Foreign
	/Medic Examir	cal	4a. Facility Name (If not institution, give		acco	4b. City, Town, or	Location of Death	Jan. 21	, 2008 4c. County	of Death	3:30 A M
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Dee	eth Day	Year	3. Time of Death
			1 = For Amend Item 2	6 per ver	b.,g875,01	1211108dhh	Death	F	Reg. No.	18	01414

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			•	of Marylan	d / Dep		Health	and Mer	ntal Hy		18 01475
	Physici	212	Decedent's Name (First, Middle, Last)						Date of Dea	ath Day	3. Time of Death
	/Medic		OLIVIA	BANKS		T			anva	V	2008 12.45 PM
	Examin	er	4a. Facility Name (If not institution, give street and			4b. City, Town	n, or Location	of Death		4c. County	of Death
ì	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 ▼	71 Age (In yrs. I	last birthday Yrs.) If Under 1 Ye Months Day		or 24 Hrs. 8. Min. 0	Date of Birt (Month, Day 9-15-	h y, Year) 1918	9. Birthplace (State or Foreign Country) MD
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or L	ocation					10d. Inside City Limits
	Maryli f sho	for	MD		RAT.T	IMORE					1 ☐Yes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Code	е			10g. Citizen of W	/hat Country?
	th wit	alD	440 MANSE CT			212	01			US	A
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any fujury or other traumatic event, I'm Madical Examinar must be notified at ances.	by Funeral	Ame 1 Yes	Decedent Ever in U. d Forces? es 2 No , Give or Dates:	S. 13.	Was Decedent of If Yes, specify C			Yes or No- an, etc.)	Black	e - American Indian, k, White, etc. BLACK
21215-0036	in 72 h	Completed	15. Decedent's Education (Specify only highest grade comple		(Give	edent's Usual Oc e kind of work do DO NOT use ret	ne during mo	ost of working		16b. Kind of Bu	siness/Industry
212	d with	mo:	Elementary/Secondary (0-12) Collection 12	ge (1-4or 5+)	ENT	REPENUE	R			HOTEL O	WNER
Maryland	uld be file fental Hyg rked otha lic event,	3e	17. Father's Name (First, Middle, Last) ERNEST BANKS						irst, Middle,	Maiden Sumam	θ)
	nd 2 shou alth and N 27 Is man		19a. Informant's Name/Relationship (Type, Print) NINA JONES/GRAND NIEC		41					BALTO.,	State, Zip Code) MD 21244
Baltimore,	Pages 1 a nent of Hei int: If Item iry or othe		20a. Method of Disposition 1 Burial ANCremation 3 Removal f 4 Donation 5 Other (Specify)	rom State	emetery, cre	osition (Name of matory or other p	olace)	Date 1/24/20			ORE, MD
Balti	permit. Depertuimports any inju		(1. Sign ture Francial Service Licensee Warman Q. W	folen	2 1	2. Name and Ad 701 LAU	dress of Faci	JAMES TREET,	A. MO BALTO	ORTON &	SONS F.H., INC 1217
760, 1	ate be executed // Medical // Medical and // Alba burial-transit //	Ical Examiner	Sequentially list conditions, b. Ducause, Later Underlying Cause (Disease or injury that initiated events c.	on each line. To (ir as a consequence of the conse	uence of): Plm Janna of):	onary 1					Interval Between Onset and Death
P.O. Box 68	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	in the past 12 months?	, outcome of pregna ive birth 2 □ Fetal regnant at time of de nknown	death 3	□Ectopic pregna □ Other (specify,				23d. Date Mor	e of delivery hth Day Year
	uires that to signed by lid be detad		Part II. Other significant conditions contributing	to death but not resu	ulting in the	underlying cause	given in Part	ı.			ibute to the cause of death? 3 Probably 4 Dunknown
Vital Records,	nyeician: The law requir nis certificete has been si I director, page 2 should	Completed							24a. Was autop perfo 1 Yes	med? p	Vere autopsy findings available vior to completion of cause of leath? Yes 2 \sum No
Vita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?				-	ce of Death (C			
o	To the Hospital or Attending Physician: within 24 hours eiter death. To the Funeral Director Atter this certific completely filled in by the funeral director.	ıtlon; To	27. Manner of Death 28a. D	ate of Injury Month, Day Year)	ER/Outpatie 28b. Time of Injury	of 28c. In	njury at Vork?	28d		dence 6 Other	
Division	e Hospital or Attenc 24 hours efter death Funeral Director: etely filled in by the	Certification;	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At ho uilding, etc. (Specify	ome, farm, si	treet, factory, office	Ce	28f.	Location (S City or Tox		er or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To Certifying P	o the best of my kno- ne basis of examinal manner stated.	wledge, dea tion and/or i	th occurred at the	e time, date a ny opinion, de	and place, and eath occurred	due to the	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)
	To the I within 2 To the I complet	M	29b. Signature and title of certifier			0 -	ense number			29d. Date signed	(Month, Day, Year)
			Ce-vitage			89	580			1/20	0/08
	3		30. Name and address of person who completed Dr - VIJAYA 2	GUDUR	1 m	Print) C/o	Man	uland (jene:	-al Has	pital
	Sta Registr		31. Date filed (Month, Day, Year) AN 2 4 2008	2. Figisibar's Signa		hand!)			1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🗓 🗓 🖰 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** January 22, 2008 8:45 A^{M} Frances A. Boyle /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel Prince George Greater Laurel Health & Rehab. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours Min. 76 1931 Maryland July 16, 214-28-3934 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ▼ Yes 2 No Director MD Prince George Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20707-4105 U.S.A. 39 Avondale Street Funeral 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛛 No Specify: Q Q 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Telephone Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Warner Anne Mallone 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Avondale Street, Laurel, Maryland 20707-4105 Thomas H. Boyle /spouse Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 1/28/08 4 □ Donation 5 □ Other (Specify) Arundel Crematory Odenton, Maryland 21. Signature of Funeral Service Licens es 22. Name and Address of Facility Donaldson Funeral Home, P.A. With 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or real fallore. List only one cause on each line. Immediate Caus (First disease or condition resulting in death) Alzheimer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Pneumonia Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Examiner be executed the attending physician and hed for use as the burial-tran Box 68760, P.O. ed by the a detached f signed b Division or Vital Records, certificate has page funeral director, After this Hospital or Attending hours after death.

Funeral

Director

d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notitled at

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is in any Injury or other traum once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Certification:

29a. Certifier

(Check only one)

29b. Signature and title of certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 0053235 29d. Date signed (Month, Day, Year) January 23, 2008

n who mp eted cause of death (Item 23a) (Type, Print) 30. Name and address of peu-

Laurel, Maryland 20707 13635 Baltimore Avenue Hill 31. Date filed (Month Par Year)

State Registrar

Medical

24 hours a

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend PII, 25, 27, 28a-f, perME, 0875, 267till 8 TT of Death

Real No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9:23 AM 2006 Frank Brady anvar /Medical 4a. Facility Name (If not institution, give street and number Town, or Location of Death 4c. County of Death Examiner Dultimore Dultimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1**√** M 2□ F 78 07/18/1929 Director Alabama 420-34-9818 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at TY⊡Yes 2□No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 14. Race - American Indian, 3300 Virginia Avenue Funeral 21215 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 √ Yes 2 No 1953 If Yes, Give Year or Dates: 1957 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0636 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel 12 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည Frank John Brady Dora Mae Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 <u> Vivian Brady / Wife</u> 20b. Place of Disposition (Name of cametery, crematory or other place) 01/31/2008 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 01/31/2008 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Owings Mills, Maryland Garrison Forest VA Ceme 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service nsee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that quised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sudden Physician /Medical Due to (or as a consequence of): Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transi Box 68760, and resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical as ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Pnd adule, Subdural hematoma 2 No 1□ Yes nrani 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 XYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. Certification: Injury 5 ☐ Pending investigation \mathbf{P}^{M} 1 🗌 Yes 12/6/2007 1:00 2 Accident Director; , Subject fell 6 Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide At Rehabilitation Center To the Hospital within 24 hours a To the Funeral C 4669 Falls Rd. Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 41 10

DHMH 17 Rev 1/2001

State Registrar Registrar's Sign

Amend #16b Per FH G875 1/30/08 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** January 21, 2008 7:00 PM /Medical <u>Charles H. Burger</u> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore <u>Long Green</u> Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 7/10/11 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) Months 18 M 2 ☐ F Yrs. Director 96 Pennsylvania 160-01-6008 Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 XYes 2 ☐ No Director Baltimore MD n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218-2407 1 East University Parkway Condo 101 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (29 Yes 2 No If Yes, Give Year or Dates: 1943-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Item on highry or other traumatic event, the Medical Experiment once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Š Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation U.S. Government (Give kind of work done di life. DO NOT use retired) during most of working Housing Elementary/Secondary (0-12) College (1-4or 5+) Urban Developement Payro11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٥ Laura Blanche Burger Henry Charles Burger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 East University Parkway Condo 101 Balto, Md. 21218 Mrs. Bessie Burger / Wife 20a Method of Disposition 20b. Place of Disposition (Name of MD .combert.errents or Grantset ry 20c. Location - City or Town, State 1. ■ Burial 2 Cremation 3 Removal from State 4 ☐Donation _5 ☐ Other (Specify) 1/31/08 Garrison Forest Owings Mills, Md. 21. Signature of Funeral Service, 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE CARDIO MYOPATHY 15ARS /Medical Due to (or as a consequence of) Examiner S - uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien and is the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): .O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PARILINSON'S DISEASE 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown PROSTATE 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No ٩ 4 Nursing Home 5 Residence 6 Other (Specify) this Irector: After this by the funeral of 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Homicide within 24 hours aft To the Funeral DI completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31136 JANUARY 23, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD., BACTIMORE, MD 21236 · WALLACE 4005 mD . Registrar's Signature 31. Date filed (Month, Day, Year)

JAN 2 4 2008

DHMH 17 Rev 1/2001

State Registrar

_			1 - For State Registrar	state of Maryland	_	rtificate of			giene Reg. No.	2008	01479
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month		Year	3. Time of Death
	/Media		WARREN L. BLA					JANUM	NY 13	7008	
	Examir	er	4a. Facility Name (If not institution, give stre				r Location of Death		4c. C	County of Death	i
69	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. la	last birthday)	If Under 1 Year		8. Date of Bi	rth	N/A	place (State or Foreign
A.	Director		212 44 7842	1 2□F 62	Yrs.	Months Days	Hours Min.	(Month, Da	ay, Year)		place (State or Foreigr intry) stralia
	yland now at		10a. State 10b. County	10c. City	, Town or Lo	cation			· · · · · ·		10d. Inside City Limits
	e Mar la-fs tiffed	ctor	Maryland Anne Ar	undel B	altimo	re					1 ☐ Yes 2 🔀 No
	ith th	Dire	10e. Street and Number		**	10f. Zip Code			10g. Citize	en of What Cou	intry?
	s 23a	ral	719 Hammonds Lane		· 1		225			J.S.A.	
980	72 hours after death with the Maryland 'ratural', or Items 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	11. Marital Status 12. 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Was Decedent Ever in U.8 Armed Forces? 1 □ XYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 12 No	lispanic Origin? (Spe an, Mexican, Puerto Specity:	ecity Yes or No Rican, etc.)	- 1	4. Race - Ameri Black, White Specify: Wh	, etc.
5-0	72 hc 'natu dical	etec	15. Decedent's Educat (Specify only highest grade co	on ompleted)	16a. Deced	lent's Usual Occup	oation during most of worki d)	ina	16b. Kind	d of Business/Ir	ndustry
Maryland 21215-0036	be filed within 72 ho ital Hygiene. id other than "natu event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired ninist	d)		Gene	eral Mo	tor
pu	be filed that Hygie dother event, the	Be	17. Father's Name (First, Middle, Last)	T D1 -1			18. Mother's Name	(First, Middle	, Maiden S	urname)	
γla		은		L. Blakemor				rie Bov			
	12 s har 7 is trau		19a. Informant's Name/Relationship <i>(Type.</i> Debra Blakemore /		1	ig Address <i>(Street</i> Hammonds	and Number or Rura Lane Ba			Town, State, Zi, ${ ilde cyland}$	
ore,	S to to		20a. Method of Disposition	20b. Pl	lace of Dispo emetery, cren	sition (Name of natory or other place	ce) [Date	20c. Loca	ation - City or T	own, State
ij	nit. Pages partment of I ortant: If Ite injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)			Crematory		8/2008	Balti	imore, l	Maryland
Baltimore,	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licensee	annum			^{ss of Facility} Go ie Highwa				e, P.A. land 21225
A. A.	Physician /Medical		23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ions that caused the death cause on each line. I YPEN KALEN Due to (or as a consequ	NIA IN				irrest,		Approximate Interval Between Onset and Death
8	Examiner -		Sequentially list conditions. b. 1	PERFORATI	ed d	DODE NA	LULUE	7			15 DAYS
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ		0015	r				15 DAY
oʻ.	execut an and rial-trar	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ		HRUEL	•		-		
68760,	tificate be executed g physician and as the burial-transit	edical	d								
.O. Box 6	death cer e attendir d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23	d. Date of deliv	very Day Year
Δ.	The law requires that the ate has been signed by the bage 2 should be detached.		Part II. Other significant conditions contrib	uting to death but not resu	Iting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	obacco use	e contribute to t	the cause of death?
rds	w requires to been signer should be o	ed by	ACUTE RENAL!	NSUFFICIE	NCY			1 🗆	Yes 2□	No 3□ Pro	bably 4XUnknown
900	ne law re has bee ge 2 sho	plet	SEPTIC SHOCK					24a. Was		24b. Were auto	opsy findings available
or Vital Records,		Completed	MYOCARDIAL IN	FARCTION	9			perfo	ormed? 2 No	death? 1 ☐ Yes	_
Vita	Physician; The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	oital: •		Loub	26. Place of Death	(Check only o	one)		110- QC 110 ₄ 5
0	S .2 ₹	2	1 165 20110	1 Inpatient 2 L	ER/Outpatien 28b. Time of		4 LI Nursing Hoi	me 5 ☐ Resi 28d. Describe			fy)
O	Attending r death. ector: After by the fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injur Worl	k?ົ` Yes 2∐No	200. 2000.100	non injury	oodaned	
Division	- Atter	Certification:	all cuiside 6 Could not be	28e. Place of injury - At hor building, etc. (Specify,		eet, factory, office		28f. Location (City or To		Number or Run	al Route Number,
	ital or rs afte ral Dir	Ser					<u>J</u>				
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physici 2 Medical Examiner	an: To the best of my knowOn the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at the tire restigation, in my o	ne, date and place, pinion, death occurr	and due to the red at the time,	cause(s) a , date and p	nd manner as solace, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
	1.1		ML m. D	•		RE	5001		JANUP	12 13	2008
i	241		30. Name and address of person who comp				00.			-	
	V	to.	DAVID PRESS 300 31. Date filed (Month, Day, Year)				BACLIMON	ve, mi	> 915	727	
	Sta Registr		JAN 2 4 2008	32 Registrar's Signat	1	and .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	3 01	480
------	------	-----

Tourish Name (Personal State Age of State A			1- For State Certificate	e of Death	Reg. No.	0 0140
## A Pacific Name of Printerinskins any activated at an exceed Transfer of Name of Country (Path Mader Choice Lear #6 23			1. Decedent's Name (First, Middle,Last)	dereon	2. Date of Death	1
278-12-4308 1			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
The State It County The State It County The State It The State are Number The State It The State are Number The State It The State are Number The State It The State are Number The State It The State are Number The State It The State are Number The State It The State are Number The State It The State are Number The State It The State are Number The State It				Months Days Hours Min.	Foreig	gn
The Minder Choice Lane CoCci 2 21,228 1	À .	_	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
The Maria Status of Processing	the Marylan a or 28a-f sl tified at onc	Director	10e. Street and Number	10f. Zip Code		intry?
Charles Clarence Kelley Blanche Pippenger The stormer's Name Realization (Type, Pint) 159. Mailing Address (Street and Number or Rural Rotale Number City or Town, State, Zp Code) Christina Osborne (daughter 5605 Sweet Air Road Baldwin, MD 21013 200. Mixed of Disposition (Same of Control Pippenger) 200. Mixed Oscillation (Same of Control Pippenger) 200. Mixed Os	er death with t , or items 23a	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Amer White, etc.	ican Indian, Black,
Charles Clarence Kelley Blanche Pippenger The stormer's Name Realization (Type, Pint) 159. Mailing Address (Street and Number or Rural Rotale Number City or Town, State, Zp Code) Christina Osborne (daughter 5605 Sweet Air Road Baldwin, MD 21013 200. Mixed of Disposition (Same of Control Pippenger) 200. Mixed Oscillation (Same of Control Pippenger) 200. Mixed Os	72 hours after n "natural", al Examiner	by	Lor Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	cedent's Usual Occupation (Give kind of v	vork done 16b. Kind of Business	
Christina Osborne/daughter Ch	5-0036 Filed within 72 Hygiene. d other than the Medical			18.Mother's Name	(First, Middle, Maiden Surname)	
The state of the s	그 용 된 호 플 [∞ '	19a. Informant's Name/Relationship (Type, Print) 19b. N	failing Address (Street and Number or F	Rural Route Number, City or Town, State	e, Zip Code)
The state of the s	MOFe, W Pages I and 2 nent of Health ant: If item 2 r other traur		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition	isposition (Name of cemetery,		r Town, State
The different contributes the final disease as a consideration of the contribution of	Dalti permit. Departm Imports injury o		21. ignature of Funeral Service Licens, e	Baltimore, MD 212	01	
Value Valu	/Medical	er	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, a. Atherosclerotic cardio Due to (or as a consequence of): of	vascular disease compli		Between Onset an
Was declared program in the program in the payment in the payment in the payment at 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24c. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 24d. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 Unknown 25. Was case referred to medical examiner? 1 Natural S Pending Investigation Investigation Investigation and Investigation and Investigation on the local search of the probable	uted d ansit		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			
Was decleted program in the payment in the payment in the payment in the payment at time of death 5 Other (Specify) 1	ate be exec ohysician ar ne burial - ti	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	, 2/19/08 TT g876, 2/1/08 TT	23d. Date of deliver	ry
The standard of the standard o	box box edeath certific the attending p		past 12 months?	=	incy Month	Day Year
The problem of the pr	uires that the	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		
25. Was case referred to medical examiner: 25. Was case referred to medical examiner: 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 25. Place of Death (Check only one) 26. Place of Injury at Work? 1 Natural of Pending Investigation on Invest	The law required that has been page 2 shoul	Complete			autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Y	completion of cause of
Natural 2 Accident 3 X Suicide 4 Homicide Specify residence Specify residence Specify residence Specify Suicide 4 Homicide Specify residence Specify residence Specify	g Physician: fter this certi	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp. 27. Manner of Death	atient 3 DOA Other Nursin	g Home 5 Residence 6 🗸 Othe	er: Scene
29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year) January 17, 2008 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	oital or Attendir urs after death. rral Director: A illed in by the fu	ertification	Natural 5 Pending Accident Investigation 1 X Suicide 6 Could not be determined (Specific) proof depression (Speci	11.20 all	28f. Location (Street and Number or R	
29b. Signature and title of certifier 29c. License number O.C.M.E. January 17, 2008 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Fo the Host vithin 24 ho Fo the Fund ompletely f		one) 2 ✓ Medical Examiner: On the basis of examination and/or investigation.			
Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	0 14 1	M	29b. Signature and title of certifier Music Russe (C.M.)		· ·	
State 31. Date filed (Month, Day, Year) 3 Registrar's Signature			Melissa Brassell, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD	21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 8:05 a Darlene Boone Jan 19, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Joseph Richey Hospice, Inc. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ x Months Days Hours Min Director 219-70-2351 Maryland Apr 13, 1959 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shormust be notified at 1 □ **¥**es 2 □ No Director Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3900 Bateman Avenue 21216 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or item I Examiner r Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify. Black "natural". Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Social Security Administration ITT Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fill hand Mental H Be Sylvester Brunson Ruth D. Brunson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 2707 Norland Road Baltimore, Maryland 21230 Patrick Brunson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages I Department of H Important: If Ite any Injury or ot 1 ☐ Byrial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 01/26/08 Baltimore, Maryland Lorraine Park Cemetery & 21. Signature of Funeral vervice Liponses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the flagth. shock, or heart fallure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erine cancer disease or condition resulting in death) lears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed and Due to (or as a consequence of) Box 68760 attending physician for use as the buris Physician/Medical SE IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 [2 ☐ No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate Vital Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA o this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and ittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) AMUARY 21,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Eutaust Baltimore, MD 21201

State Registrar 31. Date filed (Month, Day, Year)

JAN24

2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** ORNELL 200806 BROWN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EASTERN CORRECTIONAL SOMERSET M INSTITUTION WESTOVER

Je (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month), Day, 9. Birthplace (State or Foreign **Funeral** Months Days 1.M 2□ F Yrs. 214901573 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other then "natural; or Items 23a or 28a-f show and Injury or other traumatic event, the Wedical Exprintment by notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Glen Burnie Maryland Anne Arundel 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7664 Spencer Road U.S.A. 21060 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Restaurant Elementary/Secondary (0-12) College (1-4or 5+) Cook 18. Mother's Name (First, Middle, Maiden Surname)
Patricia Green 17. Father's Name (First, Middle, Last) Louis Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7664 Spencer Road Glen Burnie, Maryland 21060 19a. Informant's Name/Relationship (Type, Print) Patricia Simmons Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Church Cemetery 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 01/23/08 Pasadena, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility
Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Que to (or, as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events for as a consequence of Examine attending physicien end for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ticate hes been sig r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 1 Yes 2 3 No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 atural 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide

The law requires that the death certiticate be executed Division of Vital Records, P.O. Box 68760 To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: A

with the Maryland

Baltimore, Maryland 21215-0036

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

12 Certifying Physician: To the best of my knowledge ideath commod at the time, date and place and due to the rause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

DAVID MATHIS CORRECTIONAL 31. Date filed (Month, Day, Year)

State JAN24 Registrar

cai

32. Registrar's Signature

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 4

2008

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** HORTENSE D. CAIN 22, 20:23 M JANUARY 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPITAL BALTIMORE CITY OF If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/07/1922 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2√2 F 85 218-22-6660 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A BALTIMORE CITY M∑Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3806 WOODBINE AVENUE 21207 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 💥 ☐ No Specify: BLACK Specify: þ 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 LOUIS P. DAVENPORT KATHERINE MAHONEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN CAIN / DAUGHTER 3806 WOODBINE AVENUE, BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 01/28/08 WINDSOR MILL, MD KING MEM. PARK 4 Donation 5 Dother (Specify) 21. Signature of pneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD A. Enter the disease, or complications that caused the death bck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest. ause (Final ADRTIC ABDOMINAL diseas condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, it any taking the cause of the Cause (Disease or injury that initiated events resulting in death) Last Due to [or as a consequence of] Examine requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ➡ No 24a. Was an has certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3□ DOA 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 1 Yes 2 No death. 2 Accident the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours 1 Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 JANUARY 22, 2008 D53377 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELVEDERE AVE., BALTIMORE, MD ALI , M.D. W 2401 AHAJABIN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year,

JAN 2 4 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ricase i	State of Marylan		nt of Health and		_	
		1 - For State Registrar	State of Marylan		ite of Death	Reg. I	2000	011.85
		Decedent's Name (First, Middle, Last)		Cortino	no or boain	2. Date of Death	NOL U U U	3. Time of Death
Physicia /Medic		Hattie	Croggin.	S		January	19, 2008	3 12:00 P.M
Examin	er	4a. Facility Name (If not institution, give s		4b. Cit	y, Town, or Location of Deatl	1 7	4c. County of Deal	
		11584 Scaggsville			-ULTON		HOW	
Funeral Director		5. Social Security Number 6. Sex 1 Usual Residence of Decedent	M 20 F 7. Age (In yrs	19 Yrs.	ler 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Yes APRIL 06)	1908 NO.	thplace (State or Foreign buntry) RTH CAROLI
within 72 hours after death with the Maryland ene. then "natural", or Iteme 23a or 28a-f ehow he Madical Examination into the politiked at	tor	10a. State 10b. County MADILIAND HOLLS	10c. Cit	y, Town or Location	o Lum Bi	A		10d. Inside City Limits
with the	I Director	10e. Street and Number 91.57 HEI AIN	E HAMIET		Zip Code 2104	5 10g.	Citizen of What Co	ountry?
death me 2	Funeral	11. Marital Status	2. Was Decedent Ever in U.	S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Ame	
urs after	by Fur	1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		pecify Cuban, Mexican, Puerl	o Hican, etc.)	Black, Whit	i an V
2 hou	led ed	15. Decedent's Educ	ation	16a. Decedent's U	sual Occupation	16b	. Kind of Business	Industry
within 7 ene. then "n	Completed	(Specify only highest grade Elementacy/Secondary (0-12)	College (1-4or 5+)	(Give kind of viite. DO NOT	vork done during most of wor use retired)	RATOR D	EPARIM	WIT STAP
be filed ital Hygid of other event,	Be	17. Father's Name (First, Middle, Last)	UNKNOWN)		18. Mother's Nar	ne (First, Middle, Maid		DENT STORE
should nd Men marke imaric	2				MIN	NIE		ARNES
1 and 2 Health a em 27 le ther treu		19a. Informant's Name/Relationship (Typ. MARLOWE SAKW) 20a. Method of Disposition	S(GRANDSON)	19b. Mailing Address 9157 Place of Disposition (Nemetery, crematory)	ss (Street and Number or Ru FELAINE HA lame of	MLETWA	y or Town, State, I	EIA HO 2 KG
Page ment o ant: If ury or		Burial 2 Cremation 3 Re 4 Conation 5 Other (Specify)	emoval from State	DARBUTO	15 CEME: 01-0	23-08/3	ALTIMOR	RE, MARYLAN
Depart Depart Import any inj		21. Signature Funeral Service License	Les FKE	Jose ph	and Address of Facility 2/6	Tr. Funeral	1 Home	Daltimore
Physician		23a. Pan 1 Enter the disease, or complice ships, or hear failure. List only on Immediate Cause (Final disease) or condition	cations that caused the deatle cause on each line.	b. Do not enter the m	ode of dying, such as cardiacon Cay Cin	or respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence of the SCIT)	vence of):	diovascula	y Dige	ase	
uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):	•			
te be executed ysician and te burial-transit	cal Exa	resulting in death) Last	Due to (or as a consequent	uence of):				
ne death certificate the attending phy hed for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of di 9□Unknown	I death 3 □Ectopic			23d. Date of del Month	livery Day Year
that the de sed by the a detached	Ph	Part II. Other significant conditions con	tributing to death but not resi	ulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
ine law requires that the tie has been signed by the bage 2 should be detached.	d b					1 ☐ Yes	2 □ No 3 □ Pr	robably 4 Onknow
s bee	jet					24a. Was an	24b. Were au	utopsy findings availabl
	Completed			- 100		autopsy performed 1 Yes 2 1	3/ death?	utopsy findings available completion of cause of 2 No
	o Be	25. Was case referred to medical examiner?	ospital:	ED/O-1	1.04	th Check only one		Acc. F. D.
Ing Phys	lon: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 ☐ I 28b. Time of Injury	28c. Injury at Work?	ome 5 ☐ Residence 28d. Describe how in		icity) 1731 DJEJ 1119
el or Attending F s after death. I Director: After d in by the funera	Certification:	Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	M ome, farm, street, factory)	1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St	and Number or Ri ate)	ural Route Number,
4 hour	Medical C	29a. Certifier 1 Certifying Physic (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
To the within 2 To the Complet	Me	29b. Signature and title of certifier	^		9c. License number		Date signed (Mont	
/		٤ (lame		D30641 Neck Ro	Ja	muary.	22 2008
0		30. Name and address of person who cor Rumesh Sabapathi	201-109 B	ack kvvk	Neck Ro	ad Balt	more 1	Yaryland 217
Stat Registra		31. Date filed (Month, Day 2 4 2008	12 Registrar's Sign	Nure Salar				,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 2008 913PM Physician Ac. County of Death LUCILLE /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. Harlem Avenue 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Yrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex **Funeral** Year 1□M 2**√**F Months Days -22-74 Director MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ✓Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number permit, Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be r Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No Specify: þ 3 Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DEPT, OF SOCIAL SERVICES PROVIDER UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) (MN - LINKNOLUN) 17. Father's Name (First, Middle, Last) NDREU SILLA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOHNN ATONSVILLE MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CREMATORY 01-28-08X TRO 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dand Joseph H. Brown, Jr. 23 Part1. Ent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or it art failure. List only one cause on each line. ay 5,0 Carrinoma Immediate Cause (Final disease or condition resulting in death) wou Physician /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an the funeral director, page 2: autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending within 24 hours after deatl **To the Funeral Director:** filled in by

P.0.

Records,

Vital

ō

5-0036

Maryland

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day Year) JAN 2 4 2008

DHMH 17 Rev 1/2001

and manner stated.

Z. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)
Yelena honia, 710 knowler Chaice Lane Ball was un

52746

29d. Date signed (Month, Day, Year)

Jew., 23, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, L 2. Date of Death Month Day Physician kron 21, 2008 5:30 P^M January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4536 East Joppa Road Perry Hall 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F Months Days Hours Min. Director 212-38-2075 Dec 29, 1940 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2 No Funeral Director Perry Hall Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be **2112**8 4536 East Joppa Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) is marked other than "natu aumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Warren M. Care, Jr. Elizabeth Pinoni 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tra Judy Care, Wife Perry Hall, MD 21128 4536 East Joppa Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or Baltimore, Maryland Metro Crematory Inc. 01/22/08 21. Signature of Funeral Service Licensee
Thomas Gregor ²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Approximate
Interval Between
Onset and Death

2 Year 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Calon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or, injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) has been signed by the ge 2 should be detached 9□Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No this certificate had all director, page death? 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ို 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director; Atter th completely filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Indedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29c. License number 29b. Signature

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

140PC1

34931

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2.15 PM 2008 8 45 an /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimora Baltmara HOSP NEL of If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 □ F Director 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director moRt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: de 40 1401 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Neyer Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TOCIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IF AHO 2/229 ARROL physon 410 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from 4 □ Donation 5 □ Other (Specify) GARRISIM 21. Signature of Funeral Service Licensee FUNERAL BREADW Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. - 3 hours Immediate Cause (Final piralism **Physician** 15 Procumon to disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5124991 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)-Examiner Previous requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a 9 Unknown signed to Part JJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 2 No 3 Probably 4 Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒️No (cm 24a. Was an certificate has autopsy 2 No 1□ Yes Division or Vital To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3□ DOA ၉ 1 Minpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

LOOKMEN

DHMH 17 Rev 1/2001

m·D

M. D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

29c. License number

000

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			= For Amend Items	State of M s 28a-f pe	laryland er me ,	d / Depa g875 e/	ortment of F 01:/24/08 Unicate of	lealth and N Be ath	lental Hy	giene Reg. No∴ ∩ (0.0	01100
			Decedent's Name (First, Middle, La.)	st)					2. Date of De	ath CU	J Ö -	3: Time of Death
Ю	Physicia		ROBERT REED CHAI	BOURNE					JANUARS	Z 6, 2008	Year 8	7:03 P M
4	/Medic		4a. Facility Name (If not institution, giv)		4b. City, Town, o	or Location of Death	0	4c. County of		
	Examin	er	1715 LEISURE LANE		,		GLEN BUR	NTE		ANNE A	ARUNI	DEL
	Funeral		5. Social Security Number 6. S		ge (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da		9. Birthp	lace (State or Foreign
	Funeral Director		219-60-9560	IM 2□F	56	Yrs.	Months Days	Hours Min.	OCT. 26	5, 1951	Coun RHOD I	E ISLAND
			Usual Residence of Decedent									
	yland sow		10a. State 10b. County		10c. City	, Town or Lo	cation				1	Od. Inside City Limits
	Mar i-f sh fied	ţ	MARYLAND ANNE ARU	INDET.	GLE	N BURN	JIE					1 ☐ Yes 2 💢 No
	r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of W	/hat Cour	ntry?
	hours after death with the Maryland tural", or Items 23a or 28a-1 show al Examiner must be notified at		1715 LEISURE LANE	7			21060			UNITED S	STATI	ES
	ms 2	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S	S. 13. \	Was Decedent of I	Hispanic Origin? (Spean, Mexican, Puerto	ecify Yes or No			can Indian,
(0	r ite		1 ☑ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2 ☑	No			Specify:	nican, etc.)		k, White,	eic.
93	urs a al", c Exan	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2 🙀 No	эреспу.		Specify.	TIHW	E
21215-0036	should be filed within 72 hours after death with the Marylar and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", and items 23a or 18a-f show marke event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Deced	dent's Usual Occup	pation during most of work	kina	16b. Kind of Bu	siness/Inc	dustry
7	within 72 ene. than "nal he Medica	림	Elementary/Secondary (0-12)	College (1-4or	5+)		DO NOT use retire		ung			
21	d wit gien ar the	Ö	12			RESE	RVATION (CLERK		HOTE:	L	
	e filed al Hygie other vent, th	Be (17. Father's Name (First, Middle, Last	")				18. Mother's Nam	e (First, Middle	, Maiden Surnam	e)	
Maryland	ould be Mental arked o	To E	CLYDE CHADBOURNE					GRACE	GRAFRATI	Η		
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship	Type. Print)		19b. Mailir	ng Address (Street	t and Number or Ru	ral Route Numb	er, City or Town,	State, Zip	o Code)
			CLYDE CHADBOURNE	/ FATHER		7997	HIGHLANI	DER GLEN;	GLEN 1	BURNIE,	MD :	21061
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition			lace of Dispo	sition (Name of matory or other pla	JAN.	Date	20c. Location -	City or To	own, State
9	Pager ent o nt; If		1 Burial 2 XCremation 3 E 4 Opnation 5 Other (Speci		MET		EMATORY	OAM.		CATONSVI	LLE.	MARYLAND
≣	permit. Pages 'Department of H Important: If Ite any injury or of		21. Signan re of Fun ral S Aice Lice		111111			ess of Facility JDDICK FUI				
B	permi Depar Impor any ir		1 / Charles	X				HWY. SE;		BURNIE, I		21061
	4		23a. Part1. Enter the disease, or con	nplications that cause	ed the death							Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on sch	line.							Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	_a	rec		e py	hAlA			-	
	Examiner			Due to (or a	s a consequ	rence or):	Ta	hola.	TIBN			
,Z,		<u>.</u>	Se wentially list conditions,	b. Due to (of a	-// LA	manue offi.	1	TIPE IN			-	
	ed isit	Ę	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 0.								
	sate be executed oblysician and the burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or a	s a consequ	uence of):					-+	
8760,	be e) cian buria	ᇤ				•						
87		dical		▲d								
9 x	leath certific attending p	Me	IF FEMALE:	23c. If yes, outcom	o of progna	2001			2.20	004 5-4	to of delta	
Вох	ath c ttenc or us	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 ☐ Fetal	Ideath 3	⊒Ectopic pregnand	су		Mo	te of deliv inth	Day Year
	e de the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5L	Other (specify) _					
P.0	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions	contributing to death	but not ree	ulting in the U	inderlying cause di	iven in Part I	23e Did	tobacco use conti	ribute to t	the cause of death?
	res the	by	Fait II. Other significant conditions	contributing to death	but not rest	and in the d	maonymig oddoo gi	TOTAL CONTRACTOR		Yes 2 No		bably 4 Unknown
Records,	requi	Completed										
ec.	law las be	lg							24a. Was	DSV I	prior to co	opsy findings available = ompletion of cause of
E	sician: The law s certificate has b irector, page 2 s	, or							perf 1□ Yes	ormed?	death? 1 ∐ Yes	2 □ No
Vital	ian: ertific	Be (25. Was case referred to medical examiner?					26. Place of Dea	th (Check only	one)		
>	nysic nis ce dire	To	1 Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗌	ER/Outpatie	nt 3□ DOA Ot	ther: 4 Nursing H	lome 5 ☐ Res	idence 6 □Oth	er (Speci	ify)
0 [ng Pt ter th	<u>=</u>	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of In (Month, D	njury Day Year)	28b. Time of Injury	of 28c. Inju	ury at ork?	28d. Describe	how injury occurr	red	
<u>.</u>	ath. or: Ai	atic	2 ☐ Accident Investigation	OL/OT/2	2008	Unk	M 1	Yes 2 No	Heliu	n Asphyx	iatio	on
Division or	r Atte	l E E	3 Suicide 6 Could not to determined	20e. Place of I	njury - At ho etc. (Specif)	ome, farm, st	reet, factory, office		28f. Location			ral Route Number,
Ö	tal o	Certification:		Home	2				Glen B	rnie MD	TO TE	eisure Lane
	ospi hour uner ily fill		29a. Certifier 1 Certifying P	hysician: To the bes	st of my kno	wledge, deal	th occurred at the	time, date and place	e, and due to the	e cause(s) and ma	anner as s	stated. to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one)	and manner	stated.		, ,					
	To t To t	Σ	29b. Signature and title of certifier	0	J De	epur	Ly 29c. Licen	ise number	/	29d. Date signe	d (Month	, Day, Year)
/			Mellen	- P.C	1	and		0605	4		7/	8
(/	21		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type,	Print)	0605 5 A	3	n safan	25000	
1	21		William &	JON	185,	mr	69	5 Kh	rerice	LA C	211	035
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	strar's Signa	ture	2					
	Regist	rar	JAN 2 4 2000	1 Same	1	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** AM 7:23 2008 Baby Boy Chapman January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☑ M 2 ☐ F Director 11 Jan 6, 2008 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Prince George's Oxon Hill 1 ☐ Yes 2√ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1109 Kennbec Street 20742 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: black. Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) none none none hone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vazena Chapman Algerron Fogle 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Bayview Med Ctr 4940 Eastern Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\\Other(Specify) in state 21. Signature of Suneral Service Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cuse (Final disease or comition resulting in death) **Physician** Extreme Prematurit 14 hours /Medical Due to (or as a consequence of) **Examiner** Intection hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Acidosis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an Hypotension page 2 autopsy performe Severe certificate anemia Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 █ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

P.O. Box 68760, Division or Vital Records, After Hospital or Attending death.

Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Naturai 5 ☐ Pending investigation 1 Yes 2 No n 24 hours after death, ne Funeral Director: A pletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 [Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi and manner stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

7, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Ecker, Do Avenue Bathmore MD

State Registrar

31. Date filed (Month, Day, Year) JAN 2 4 2008

				rieas								-	Ale Legi	DIE.	
					State	of Maryla		ertificat					201	0 8 (1491
	_		Decedent's Name	/Circl Middle	(ant)			Cillicat	e ui	Deaui		Dete of Dee	leg. No.	3.7	Time ot Death
	Physic	an										Month	Day _	Year	1200
1	/Medi		Bay Girl 4e Fecility Name (If re			number)				4b. City, To	wn, or Locati	on of Deeth	4c. County		120
J	Exami	ner	10	•		talCe	ster			1	verly	/	_	ce Ge	mes
			5. Social Security Nur		Sex		rs. last birthd	av) If Under	r 1 Year		24 Hrs. 8.	Date of Birth	1	9. Birthplace	State or Foreign
	Funeral Director				1□ M 21 F		Yrs	Months	Days	Hourse	Min.	(Month, De)	(, Year)	Mary 6	. 0
		•	none Usuel Residence of D	Pecedent									1	1	
	show		10a. State	10b. County		10c.	City, Town o	r Location							side City Limits
	Mar	ģ	MD	Prince	George	's N	ew Car	rollto	n					1	☐ Yes 21 No
	rith tha Maryle or 28a-f shor	9	10e. Street end Numb	er				10f. Zip	Code				10g. Citizen of V	Vhat Country?	
	h wit	Funeral Director	4909 71st	Avenu	2					20784	ŀ		US	A	
	daa	ner	11. Marital Status		12. Was D	ecedent Ever in Forces?	u,S.	3. Was Deced	dent of H	lispanic Orig	gin? (Specify	Yes or No-	14. Raci	e - American Inck, White, etc.	dian,
20	within 72 hours after daath with tha Marylend ena. than "natural", or items 23a or 28a-f show ha Medical Exarriner must be notified at	y Fu	1 ☐XNever Married		1 □ Ye If Yes,	s 2 XNo		1 ∏ Yes					Specify		e
Ö	tural,	Completed by		5. Decedent's		. 50100.		cedent's Usua					16b. Kind of Bu	usiness/Industry	,
5	in 72	jet	(Specify	only highest g	rade complete		(G	ive kind of wo e. DO NOT u	rk done se retire	during most d)	t of working				
212	with the	E	Elementary/Second none	lary (0-12)	none	e (1-4or 5+)	noi	ne					none		
g	be filed with stal Hygiena. d other than event, the N	BeC	17. Fether's Name (Fi	irst, Middle, La	st)			unk	ζ	18. Mothe	er's Name (Fi	irst, Middle,	Maiden Sumam	10)	
<u>a</u>		To B									Lexan	dra Ca	anales		
Maryland 21215-0020	2 should be and Menta is marked raumatic ev		19e. Informant's Nam	ne/Relationship	(Type, Print)		19b. M	ailing Address	s (Street	and Numbe	er or Rural Re	oute Numbe	r, City or Town,	Stete, Zip Code	9)
	od 2		Prince Ge	orge's	Hospit	al Cent	er 3	001 Ho	snit	al Dr	ive Ch	ever1	v MD	20785	
ହ	ges i and 2 it of Health If Item 27 is or other tre	1	20a. Method of Dispos		11001120	200	D. Place of Di	sposition (Nar	me of			ate	20c. Location -		State
9	eges t: If I		1 Donation 5	Cremation 3	□Removal fro	m State	cemetery,	demaiory or c	nii piat	Ce)	i				
Baltimore,	permit. Peg Depertment Important: I any injury o pnce.	i	21. Signature of Fund	ral Service Lic	ense 2			22. Name an	vd Addre	ss of Facilit	ly .		20 VII.	2.1	7725
Ba	permit. Deperti import any inj pnce.		Ro	nald 6.	Wade,	Direct				_		55 W.	Baltim	ore Str	eet
		_	Jun	N//	11/11			Baltimo			21201	onicaton, as	roet	Ann	rovimate
			2 a. Pert1. Enter the shock, or heart	failur. List on	ly one cause o	n each line.	eeth. Do not	enter the mod	e or dyn	ig, such as	cardiac or re	ispiratory ar	iest,	Inter	roximate val Between et and Death
1	Physician /Medical		Immediate Cause (Fi	inal	1	- ,	1								
	Examiner		disease or condition resulting in death)	idi	0. //	rached Due to	al Efe	znoc;	5						
ì		<u></u>	,		* /	Due to	o (or es e con	sequence of):						i	
	ted 1sit	Examiner			b. //	1/ER	(1)	ociai	1ac	1				<u> </u>	
_	be executed ician and bunal-trensit	xar	Sequentially list cond if eny, leading to imm cause. Enter Underly Cause (Disease or in	itions, lediate		Due to	o (or as e con	sequence of):							
760	e be ey sician e buria	calE	cause. Enter Underly Cause (Disease or in	ring jury	C										
687	phys the	edic	that initieted events resulting in death) La			Due to	(or as a con	sequence of):							
×	ding Se as	Me		· ·	d										
Вох	leath certificete attending phy: I for use as the	cian													(1.110
	requires that the death certificete be executed een signed by the attending physician and hould be datached for use as the bunal-trensi	Completed by Physician/M	Part II. Other significa						ause giv	ven in Part I					cause of death?
P.0	that the by data	됩	Congei	intal	card	iac a	isea.	se				111	res 212 No	3 ☐ Probably	4 ☐ Unknown
ds,	ires tha signed d be dat	D D	01			arter						24a Was	an autopsy	24b. Were a	utopsy findings
Ö	v require been sign should t	etec	Smale	, unt	utical	arter	/						med?	complet	e prior to tion of cause
ě	S 50	ğ	J			1								of death	
=	Pe age	S									-	10Y	35 2 100	1 🗆 Yes	2 □ No
/ita	ician: The certificate irector, peg	Be	25. Was case referred examiner?	d to medical	Manageria				04		of Death (C	heck only o	ne)		
Division of Vital Records,	Physician: this certific rel director,	P	1 Yes 2 LN	ó	-		□ ER/Outpa		-	4 LINU			lence 6 Oth		
ב	a fe d	on:	27. Menner of Death 1 D Naturel	5 Pending		te of Injury Jonth, Dey Year,	28b. Tim Inju	ry	28c. Injui Woi	rk?		. Describe h	ow injury occur	Det	
sio	ttandi death. ctor: A y the fu	cat	2 Accident	investigat	he -			М		Yes 2□		Location "	Managar of Alice 1	or or Down I Do	ito Number
Ž	fred fred n by	Certification:	4 ☐ Homicide	determine	200. FIE	ece of Injury - A ilding, etc. (Spe	i home, farm ecify)	, street, factor	y, office		281.	City or Tox	Street and Numb vn, State)	o Hurai Hol	na ivuiliber,
	To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A completaly illiad in by the fo	ပိ						2.4				10.00			
	Hosp 14 hou Fune taly fi	edicai	(Check only 2	☑ Certifying F ☐ Medical Ex	aminer: On the	basis of exami	onowledge, d ination end/o	eath occurred r investigation	et the tir , in my o	me, date an opinion, dea	nd place, and oth occurred a	due to the o at the time, o	cause(s) and ma date and place,	anner es stated and due to the	cause(s)
	the the I	Med	one)	le of earliffe	and m	anner steted.		20.	c Licere	se number		1	29d. Date signe	d (Month Day	Year)
	S 4 ₹ 5		29b. Signature and tit	ie of certifier	1		1			i — —	~~~7	'	Lou. Date Signe	La (Mondi, Day,	. 561/

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician CONAWA 8:40 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Baltimore Randallstown Northwest Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2X F Months 212-22-3995 Director 3/1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show Examiner must be notified at XXYes 2 □ No Director Windsor Mill N/AMd 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with tent of Heatth and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 3 5533 Old Court 21244 Funeral Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify δ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coca Cola Employee Coca Cola Bottling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Diggs ပ Elizabeth Diggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau once. Edward Conaway 5533 Old Court, Windsor Mill, Md. 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State I∏ Burial 2 □ Cremation 3 □ Removal from State Druid Ridge 4 Donation 5 Other (Specify) 1/22/2008 Pikesville, Md. 21. Signature of Funeral Service Lio-see ²² Name and Address of Facility
Estep Brothers Funeral Service, PA
1300 Eutaw Place, Baltimore, Md. 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Infarction **Physician** Myocardia /Medical (or as a consequence of) Examiner Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to for as a nonsequence of: or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ Periphera 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 400 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Certification: To 1 Yes 2 No 1 4 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 8 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January, 17, 2008

State Registrar

5401 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Old Court Road, Randallstown, MD 21133.

08-00526	
Dana Cromartie	

Flease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Dana Cromartie		State of Maryland / Department of He For State Certificate of De			g. No. 200	8 0149
Physician	1	Decedent's Name (First, Middle,Last)		2. Date of Death	1	3. Time of Death
Medical Examine	•	Dana Cromartie a. Facility Name (if not institution, give street and number) 4b. Cit	y, Town, or Location of De	Month January 18	4c. County of Deatl	1714 hrs
			Itimore		N/A	
Funeral Director		Mc Mc	Inder 1 Year If Under 24 onths Days Hours	4Hrs. 8. Date of Birth Min. 11/22/	h(MM/DD/YYYY) 9. Bii Forei / 1 0 5 7	
		216-68-8364 1X M 2 F 50 Yrs.		μ1/22/	1901	
w any	ſ	0a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 X Yes 2 No
yland once	ع ا	Md. N/A Baltimon	CE Zip Code		g. Citizen of What Cou	
with the Maryl ms 23a or 28a-1 be notified at a			1215		USA	,
er death with the Maryland or items 23a or 28a-fah craust be notified at once		1. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		rican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should he filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Department of Health and Mental Hygiene. The Department of Health and Medical Examiner must be notified at once.	בות בות	1 Yes 2 X No	2 X No specify:		Specify: B1	ack
hours a	Completed by	during most of	ual Occupation (Give kind working life. DO NOT use		16b. Kind of Business	/Industry
36 nin 72 e. than "dical J		Elementary/Secondary (0-12) College (1-4 or 5+) 12 Disab	led		Never Wo	rked
5-00 ed with	5	7. Father's Name (First, Middle, Last)		Name (First, Middle, M		
1218 The fill ental H rrked	a	Joseph R. Cromartie		ın B. Ful		
D 2.	- (1	ress (Street and Number			
and 2 Tealth item 2		20a. Method of Disposition 20b. Place of Disposition	Name of cemetery,	Date	20c. Location - City of	e . Md . 21215 r Town, State
mord Pages 1 ant of 1 nt: If	- 1	1 X Burial 2 Cremation 3 Removal from State crematory or other pl	' I	/25/2008	Laurel,	Marvland
Saltir ermit. J epartm mports njury or	t	22. Sunature of Funeral Society.	and Address of Facility tep Brothe 00 Eutaw P	rs Funer	cal Servi	ce clos
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo	OD Eutaw Pode of dying, such as card	Lace, Bal	est, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Diabetic ketoacidosis				Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, fi any, leading to immediate cause. Enter Underlying Cause Cause.				
d d	EΓ	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
60, ate be executed hysician and e burial - transit	- Cal	d				
60, ate be ohysici	Med	F FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	ery
30x 6876 death certificate e attending phy for use as the	lan/	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal de 4 Pregnant at time of death 5 Other (eath 3 Ectopic pr (Specify)	regnancy	Month	Day Year
Box e death c the atten ed for us	ly Sic	1 Yes 2 No 9 Unknown 9 Unknown	Specify/			
5, P.O. Bi	S P	Part II. Other significant conditions contributing to death but not resulting in the under	ying cause given in Part I		obacco use contribute t	o the cause of death?
ords, F w requires s been sign should be					an 24b. Were	autopsy findings available
COFC law re has be e 2 sho	Completed				rmed? death?	
tal Rec		25. Was case referred to medical	26.Place of Death (Cl		2 No 1	Yes 2 No
Vita ysician this cer direct	8 9	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	DOA Other	Nursing Home 5	Residence 6 Oth	er:
n of Vii	 	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?		how injury occurred	
Division of Vital Records, P.O tal or Attending Physician: The law requires that test after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deaced.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, fac		28f. Location (Rural Route Number, City
Divisi Divisi ours after de neral Direct filled in by		4 Homicide determined (Specify)		or Town, S		
	<u></u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in the control of the control	it the time, date and place in my opinion, death occu	e, and due to the causured at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
To To con	Ē	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (A	
€ FI		Calmery).	O.C.M.E.		January 19, 20	08
(5)	ſ	30. Name and address of person who completed cause of death (tem 23a) Zabjullah Ali, M.D. Assistant Medical Examiner 111 Penn S	treet, Baltimore, MI	D 21201		
Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature			OCME	
Registra		JAN 2 4 2008 Januar St Januar				
DHMH 17 Rev 1/200 OCME 2006)1	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANÜÄRY 2008 HARRY PHILIP 10:10A M CAPLAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death HOSPICE OF BALTIMORE GILCHRIST CTR. TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/19/1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 10 M 2□ F 93 218-01-3941 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ∐Yes 2 No BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8911 REISTERSTOWN ROAD 21208 USA 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** GROCERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CAPLAN LOUIS ANNA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PEARL CAPLAN / 9044 MEADOW HEIGHTS. RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BNAI ISRAEL CONG. 01/23/2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐Ectopic pregnancy Year Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 2 ☑ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show ner must be notified at

"natural", or

1 and 2 should be filed within 72 hours after death Health and Mental Hyglene.

permit. Pages 1 and 2 should be filed \
Department of Health and Mental Hygle |
Important: If item 27 is marked other i any Injury or other traumatic event,

any Injury or other traumatic event,

⊈

Baltimore, Maryland 21215-0036

Director

Funeral

þ

Completed

Be

ပ

and signed by the attending physician this completely filled in by the funeral After To the Hospital or Attendii within 24 hours after death.
To the Funeral Director: A

Completed by Physician/Medical

Be

Medical Certification: To

IF FEMALE 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 DUnknown

Part H. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yes 2 No 27. Manner of Death

5 | Pending investigation

6 ☐ Could not be

2 ER/Outpatient 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 □ DOA 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of contifier

, no

Charles St.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BMC 6701

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** RACHEL JANUARY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ESSEX RIVERVIEW CARE CENTER BALTIMORE COUNTY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours Director CANADA 077-14-7156 AUGUST 18 1914 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 ☐Yes 2 No Director BALTIMORE MARYLAND DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U, S, A,

14. Race - American Indian, Funeral PLACE IDI CENTER 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 YRS, PAACTICAL WURSE NIA CHURCH HOME HESP, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည JOSE PH ST. DENIS AMANDA GAUTHIER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 Is any Injury or other traconce. SHARON MISKIMON/DRUGHTER Ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY JANUARY25, CB BALTIMORE, MD 22. Name and Address of Facility LILLY + ZEILER, WE, FUNERAL HEMES 21. Signature of Funeral Service Licensee Catherine M. 1901 EASTERN AVE, BALTIMORE, MO, 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician nevroma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 Probably 4 Striknown Completed neula 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1∐ Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Theorem 4 Theorem 5 American 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hirespee D19667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4508 Glen Boring Ald 20061 7310 Lucul Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Da)

4 2

JAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			. For	State of Maryla	ind / Depa	rtment o	f Health and M	Mental Hygie	menns	01496
			State Registrar		Cer	tificate c	of Death	Reg.	No.	01.400
	Physicia		1. Decedent's Name (First, Middle, La	Thelm	a E	220		2. Date of Death Month	Day 9 Year	3. Time of Death 8 1: 20 AM
	/Medic Examin	_	4a. Facility Name (If not institution, gi		~ 1	4b. City, Tow	n, or Location of Death		4c. County of Deat	h
*			St- Elizabeth	Nowsing (enter	150	ar If Under 24 Hrs.		0.00	(6)
	Funeral Director			Sex 7. Age fin yr. 1 □ M 2 ☑ F 94	s. last birthday) Yrs.	If Under 1 Ye Months Da		8. Date of Birth (Month, Day, Ye Mar 14,	9. Bin 1913 Oh	hplace (State or Foreign nuntry) 10
	and .		Usual Residence of Decedent 10a. State 10b. County	10c. 4	City, Town or Loc	cation				10d. Inside City Limits
	Maryl f sho	ρ	MD Howard	CC	olumbia					1 ☐ Yes 2X No
	h the	Director	10e. Street and Number			10f. Zip Coo	de	10g.	Citizen of What Co	ountry?
	23a c		10001 Windstream			2104			.S.A.	
	er de	Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🕅 No	U.S. 13. V	Vas Decedent Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puert	pecity Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show amy njury or other traumatic event, the Maryland Exeminant must be notified at Andrew.	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2🏻	No Specify:		Specify: Whi	ite
2-0	72 ho	Completed	15. Decedent's E (Specify only highest g	Education rade completed)	(Give	lent's Usual Ockind of work do	one during most of wor		. Kind of Business	Industry
121	within ene. than '	ldmo	Elementary/Secondary (0-12)	College (1-4or 5+) 4	Homem	00 NOT use re Jaker	тігөа)	0	wn Home	
0 0	filed Hygie other ent, the	Be Co	17. Father's Name (First, Middle, Las	-	Homen	akcı	18. Mother's Nar	ne (First, Middle, Mai		
ılan	uld be Mental rrked	To B	Francis Hammerst	ein			Estella	Zapp		
lan	2 sho and h ie me		19a. Informant's Name/Relationship				reet and Number or Ru			
	1 and Health em 27 ther t		Fleurette A. Car 20a. Method of Disposition		. Place of Dispos	sition (Name o	stream Dr.		lumbia, No. Location - City or	
nor	ages ant of l it: If It		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	cemetery, cren rlington	natory or other	place)	29, 08 Ar	lington,	Virginia
Baltimore,	nat. Poartme		21. Signature of Funeral Service Lice		22	. Name and A	ddress of Facility			. == 5=
ä			Voll ff		0773 3	13 Tal	on Funeral bott Ave.	<u>Laurel, Ma</u>	ryland 20	
\$			23a. Part1. Enter the disease, or co shock, or heart failure. List onl	mplications that caused the de ty one cause on each line.	eath. Do not ente	er the mode of	dying, such as cardial	or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a	-ailar	e +0	Turive			Mun Mis
	Examiner		1	Due to (or as a cons	emilia or):	entia				very 1
7	ם ב	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		1				
V	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):					
760,	te be executed ysicien and e burial-transit	cal E	(ď						
89			15.551.41.5							
30X	ath cer ttendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre-	etal death 3	Ectopic pregn			23d. Date of de Month	livery Day Year
P.O. Box	Attending Physician: The law requires thet the death certificate be executed rideath. If death. ector: After this certificate has been signed by the attending physicien and but the tuneral director, page 2 should be deteched for use as the burial-transit.	Physician/Med	1 ☐ Yes 2 ☐ XNo 9 ☐ Unknown	4∏Pregnant at time o 9∏ Unknown	of death 5	Other (specif	y)			
	s thet t ned by e deta	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying caus	e given in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
ıds	v require been sig should b	1 Yes 2 No 3 Probably No Nutri 1 1 1 1 1 1 1 1 1								robably Inknown
ecc	faw ra nas be e 2 sh	Completed	Pressure Ul	cer				24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
ai H	Physician: The lav this certificate has al director, page 2		os War and advanta and al				00 00	1 ☐ Yes 2	No 1 ☐ Ye	s 2 No
Ξ	s certil	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatier	nt 3 DOA		ath <i>(Check only one)</i> Home 5 ☐ Residend	ce 6 ∏Other (Spe	ecify)
0 ر	ng Phy ter thi neral o	T:uc	27. Manner of D. ath 1 X Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of		Injury at Work?	28d. Describe how		
sior	tendir eath. tor: Af the fu	catic	2 Accident investigat	the -		М	1 Yes 2 No	004 1 4: / (C4		Description of the second
Division of Vital Records,	al or At	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (St. City or Town							iurai Houte Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my taminar: On the basis of examinar and manner stated.	knowledge, death ination and/or in	h occurred at the vestigation, in	he time, date and place my opinion, death occ	e, and due to the causurred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	727	44		cense number		. Date signed (Mon	
				1 3	ino		15-5-39	1	anumy	21,2008
	12		30. Name and address of person wh	no completed cause of death ((L) AL	Print)	Kultin	ere IM	arylon	21,2008 d 21227
	Sta Regist		31. Date filed (Month, Day, Year)	2008 32. Rigistrar's Si	gnaturd	ments!				

08-00538							
Elgin	Etchison						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Ŭ			1- For State Registrar	or ivial yland /		ate of De		a wentari		eg. No. 2	008	3 0 1	49
Medic	Physici cal Exami	an/ ner	1. Decedent's Name (First, Middle Las	inson; Jr.	: m MaVan	dwa Etal	hi oon	πD	2. Date of Deat Month January 1	Day Y	/ear	Time of Death0501 hrs	n
	Jui Exam.		Elgin M. Etchis 4a. Facility Name (if not institution, giv		III ricken			JK Location of Deat			ty of Death		
			Shady Grove Adventist Ho	· ·		Ro	ockville			Montg	omery		
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last bir	-	Under 1 Year		_	th(MM/DD/YY	YY) 9. Birti Foreigi	nplace (State or Washing Intry)	≥ton
	Director		212 02 1371	M 2 F	40	Yrs.	Jay C	110010		4, 196	7 Cou	intry) D	.C.
	any	ŀ	Usual Residence of Decedent 10a. State 10b. County	[1	0c. City, Town	or Location						10d. Inside City	Limits
\circ	*	5	Maryland Montgo	mery	Gaitl	nersbur	g					1 X Yes 2	No
1400	Maryl 28a-f d at o	Director	10e. Street and Number			10f	. Zip Code		1	0g. Citizen of	What Coun	try?	
1	with the Maryland ns 23a or 28a-f sho be notified at once		630 Lakeworth D				20878				d Sta		
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once	Funeral	11. Marital Status1 Never Married2 Married					panic Origin? (S , Mexican, Puert	Specify Yes or No o Rican, etc.)		hite, etc.	can Indian, Black	ζ,
	ifter de II", or ner m		3 X Widowed 4 Divorced	1 Yes 2 X	No	1 Yes	2 X No	specify:		Specif	fy: W	Mhite	
	hours a	g	15. Decedent's Education (Specify of					ion (Give kind of DO NOT use re		16b. Kind of	Business/l	ndustry	
36	d be filed within 72 hours aft lental Hygiene. arked other than "natural" event, the Medical Examina	Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+	-)		_	ng Agent		Plumbi	ing ar	ıd Heati	no
0	ygien ygien other	Ö	17. Father's Name (First, Middle, Last						ne (First, Middle,			id Heati	6
21215_0036	uld be file Mental H marked o	Be	Elgin M. Etchis		200			Barbar					
		입	19a. Informant's Name/Relationship (T		2.0				Rural Route Nur				
2	a g g g g		Barbara B. Etchi 20a. Method of Disposition	son / Moth		30 Lake of Disposition		metery,	Gaithers Date	20c. Location	Mary I on - City or	and 208 Town, State	78
o d	ges 1 It of H It If it		1 Burial 2 X Cremation 3		٥	tory or other p		I 00	nuary				
Raltimore	permit. Pages 1 Department of 1 Important: If injury or other		4 Donation 5 Other Specify 21. Signature of Funeral Service Licer		Montgon	ery Cren	atorium and Address		, 2008 bert A.	Pumphr	ev Fr	<u>Marylan</u> meral H	d lome/
ä	Dep Dep 1		M. M. Wa		M01473	Rockv Rockv	ille, ille,	Inc. 3 Marylan	bert A. 00 West d 20850-	Montgo -2805	méry	Avenue,	
	Physician /Medical		23a. Part I. Enter the disease, or comp failure. List only one cause on ea	ach line.		ot enter the m	ode of dying,	such as cardiac	or respiratory arr	rest, shock, or	heart	Approximate Between Ons	Interval set and
	xaminer		Immediate Cause (Final disease a. or condition resulting in death)	Narcotic int		on assoc	iated wi	ith acute	bronchopne	eumonia		Death	
			Sequentially list conditions, b.		quence or).								
		iner	if any, leading to immediate	Due to (or as a consec									
		Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):								9
V	e be executed ysician and burial - transit		d.			877 3/4	/08 TT			·			
9	te be ex ysician burial	Medical	X UNPENDED	AMENDED #1,23a,27,2 23c. If yes, outcome			5, 2/26/	/08 TT		23d Date	e of deliver	,	
	rtificati ling phy		23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal d	eath 3	Ectopic pregi	nancy	Monti			ear
Bov 687	that the death certifined by the attending detached for use as t	Physician/	1 Yes 2 No 9 Unknown	Pregnant at ti	me of death	5 Other	(Specify)						
	t the d		Part II. Other significant conditions	1	but not resulting	ng in the unde	rlying cause o	given in Part I.	23e. Did t	obacco use co	ontribute to	the cause of dea	ath?
٥	es been signed be detail	d by							1 Ye	es 2 No	3 Prol	oably 4 🗸 Unl	known
Division of Vital Records	request should	Completed							24a. Was auto	psy	prior to	topsy findings a completion of ca	
200	The la	mo							1 ✓ Yes	ormed? 2 No	death? 1 ✓ Ye	es 2 🗌	No
2	certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:				Other Nurs		1			
<u>`</u>	Plysic Plysic er this eral dir	욘	1 ✓ Yes 2 No 27. Manner of Death	T Inpation	t 2 🗸 ER/0	Outpatient 3	DOA / 28c. Iniu	iry at Work?	sing Home 5	Residence		r:	
2	nding uth r: Aft	ig	1 Natural 5 Pending	28a. Date of Injury (Month, Day,Yes	ar)	nd 4:00 /	1	Yes 2 _Y No	unk	,,,,			
jej	or Atte ter des irecto irecto	fical	2 Accident Investigat 3 Suicide 6 X Could not	29a Place of Init				building, etc.	28f. Location		umber or Ru	ıral Route Numb	er, City
ć	pital o	Certification:	4 Homicide determine		ound at 1	nome			630 Lake	eworth D	r. Gait	hersburg	, MD
A	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pa e 2 should be detached for use as the burial - transi		29a. Certifier (Check only one) 1 Certifying Physic Certifying Phy	ian: To the best of my	knowledge, de	eath occurred investigation.	at the time, d	ate and place, ar	nd due to the cau	ise(s) and mar	nner as stat	ed. ne cause(s)	
1)	To t with To t	Medical	29b. Signature and title of certifier	and manner stated.			29c. Licens		-, -, -,			nth, Day, Year)	
			My W.	mP			o.c.	M.E.		1	19, 200		
	otal		30. Name and address of person who	completed cause of de			L						
į	5 pend			ledical Examiner		nn Street, E	Baltimore,	MD 21201					
	S	tate trar	31. Date filed (Month, Day, Year)	32. Fegistrar	s Signatur	1000	ري						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 3,45 PM Physician 2008 son JANUAKY /Medical 4c. County of Death 4b. City, Town, or Location of Death institution, give street and n Examiner Nemorial 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number In vrs. last birthday Funeral Days 227-46-208 Months Hours 1 □ M 2 ▼F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at allimore 1 Yes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 Hvenue estmont 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2 🔣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Blac Completed by 3 NWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working lite: 90 NOT use retired dary (0-12) College (1-4or 5+) lath Mother's Name (First, Middle, Maide ther's Name (First Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Prin BaHo 20c. Location - City or 20a. Method of Disposition Burial 2 Cremation 3 ☐ Removal from State Noodlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) reeks. **Physician** Phreumonia /Medicai Due to (or as a consequence of): **Examiner** rome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed yocardia and Due to (or as a consequence of): burial-1 Box 68760, signed by the attending physician Physician/Medical as the IE EEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month ō in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. F detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ þe 1 | Yes 2 No 3 | Probably 4 | Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No has page 2 s autopsy perform certificate 2 No Yes Attending Physician: 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: 2 No 1 Impatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT 2438946 C--19 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LNION MEMORIAL 1-1 KOBERT NNERY 3 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 4 Registrar 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25, per NE, 9875, 1/25/08 TT

Amend Item 23a per dr., 9875, 01/24/08d1b Department of Health and Mental Hygiene 5.01.724.08dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY Day 12 **Physician** 2:50 P JOYCE FENICHEL 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔏 F 215-22-2522 Yrs. 82 10/29/1925 Director MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 X No MD BALTIMORE Funeral Director WINDSOR MILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3416 JANVALE ROAD 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes . 2M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. WHITE 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** TRAVEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY BRIM 2 **EMMA** HURWITZ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) IRVING FENICHEL / HUSBAND 3416 JANVALE ROAD WINDSOR MILL, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP 01/16/2008 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 21. Signature of Funeral Service Licensee such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** con disease or condition resulting in death) /Medical Examiner VAPPROVED BY IMEDICAL EXAMINER Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for he min neurospino. Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran and CERTIFIC Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 Probably 4 Unknown Recurrent Aspiration Pneumonia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 After this certificate 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 45 dursing Home 5 Residence 6 Other (Specify) 1 X Yes 3□ DOA 1 Inpatient 2 ER/Outpatient Medical Certification: To To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No a Accident 6 □Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier and address of person who completed ause of death (Item/23a) (Type, Print) Registrar's State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2008 SANUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 18, 2008 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours Min. 1**∑** M 2□ F Maryland Director none Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene.

other than "natural", or items 23a or 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐ Yes 2√ No Director ELLICOTT City Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21043 3258 Normandy Woods Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: white ğ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental I 90 Jennifer Fernandes Kumar Devarag 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 600 N. Wolfe Street Baltimore, MD Department of Health a Important: If Item 27 Is any Injury or other trains Johns Hopkins Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state State and Address Face Board 655 W. Baltimore Street Funeral Service Dicensee Wade Director Baltimore, MD 21201 Port1. Enter the dis * se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, six ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 8m Due to (or as a consequence of): Immediat Cause (Final Physician disease or condition resulting in death) /Medical Examiner Memo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 XNo 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an ate has bage 2 s performe 2 No 1∐ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 ☑ No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and of certifier RES - 000 MI

State Registrar 31. Date filed (Month, Day, Year) JAN 2 4 2008

Smith

2008 3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Bathmone,